

2019 Florida Fest Boys' Bid Tournament

1/26/2019 - 1/27/2019

Team Club: Nona Sports 14 U-B
 Team Code: MJ4NONAS1FL
 Division: 14 Open

Jers. # / Pos.	Name	USAV #	USAV Ver.	Birthdate	Coach Cert.	BGS Ver	SafeSport	Impact	Added
21 DS	Alberti, Alejandro	FL2986101MOJ19	Y	06/12/06	Player	-	-	-	01/06/19
11 Middle	Almanza, Sebastian	FL3233405MOJ19	Y	08/16/05	Player	-	-	-	01/06/19
32 Middle	Anglero, Leonardo	FL2985961MOJ19	Y	07/21/05	Player	-	-	-	01/06/19
1 Right	Browning, Tristan	FL2985139MOJ19	Y	10/05/04	Player	-	-	-	01/24/19
17 Right	Licon, Jayden	FL3231766MOJ19	Y	02/04/05	Player	-	-	-	01/06/19
16 Left	Matos, Fabian	FL3123598MOJ19	Y	12/15/05	Player	-	-	-	01/06/19
7 Left	Medina, Antonio	FL2986676MOJ19	Y	10/23/05	Player	-	-	-	01/06/19
12 Setter	Wishart, Vincent	FL2817128MOJ19	Y	05/06/06	Player	-	-	-	01/06/19
Head Coach	Anglero, Leonardo	FL2458629MOA19	Y	02/07/78	IMPACT	USAV	USAV	USAV	01/06/19

Roster size: 9 (8 players and 1 staff members)

** Denotes player is team captain, [W] Denotes waived player

Event Roster & Medical/Emergency Release Form Requirements

1. The above roster is correct and contains all players who will be participating in the event. All players listed on the roster must be registered or members in good standing with their respective Member Organization.
2. All players must meet age classification requirements. NOTE: Age Waiver players are NOT eligible for Qualification events and National competitions (National & Regional Qualifiers and the Junior Nationals).
3. All staff listed on the roster must be registered or members in good standing with their respective Member Organization: have completed SafeSport certification and cleared the approved background screening. A staff member listed on the roster for the team/club will be with this team/club at all times during while attending this competition.
4. All coaches are required to be at a minimum Impact certified.
5. A staff member listed on the roster for the team will be with this team and have in their immediate possession at all times during this competition a complete and legible copy of the Medical/Emergency Release Form for each player listed on the official roster.
6. The team understands it is subject to any and all penalties for incorrect or incomplete information on this form.

Leo Anglero
 Print Name

407-234-6323
 Phone Number

[Signature]
 Signature

1/24/2019
 Date

THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.



2018-2019 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. **By signing this form the participant affirms having read and agreed to the terms and conditions listed below.**

Club: Nona Sports Team Name: Nona Sports 144-B
Alejandro Alberti 6/12/06 12 Male Female
First Name Last Name Birth Date Age

Primary Contact: Parent or Guardian
Name: Laura Reyna Address: 9429 Candice Ct.
City, State & Zip Orlando, FL 32832
Primary Phone: 407-719-5183 Alternate Phone: _____

Secondary Contact: Parent/Guardian Other _____
Name: Jorge Alberti
Primary Phone: 407-416-5107 Alternate Phone: _____

Primary Insurance Co Aetna Primary Group/Policy # 285681-013-001051 W2433 63968
Family Physician Name Tree House Pediatrics Physician Phone 407-736-8733

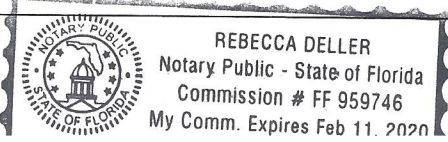
Please elaborate on any medical conditions of which we should be aware:
N/A
Please list any medications currently being taken:
N/A
In the past 24 month, have you been tested, diagnosed and/or treated for a concussion: Yes No
If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:
Please list any allergies: NONE
If None, please write None.

Participant Signature _____ Date: _____
(regardless of age):
Participant, Alejandro E. Alberti, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized team/RVA personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.
Parent/Guardian Signature: Laura I. Reyna Date: 1-10-19
Relationship to Participant: mother

If, during the course of my daughter's/son's activities in volleyball, should she/he become ill or sustain an injury, I hereby
 AUTHORIZE or **DO NOT AUTHORIZE** (Select only one option to ensure validity of this document!)
you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Parent/Guardian Signature: Laura I. Reyna Date: 1-10-19

STATE OF Florida) COUNTY OF Orange)
SWORN TO BEFORE ME, a Notary Public, by said Laura Reyna personally known
to me this 10th day of January, 2019
Notary Public [Signature] My Commission Expires 2/11/2020



THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.



USAVolleyball.

2018-2019 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This must be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. **By signing this form the participant affirms having read and agreed to the terms and conditions listed below.**

Club: Nona Sports Team Name: B14
Sebastian Almanza 8/16/05 13 Male Female
First Name Last Name Birth Date Age

Primary Contact: Parent or Guardian
Name: Michelle Lopez Address: 8710 Sidley Lane
City, State & Zip Orlando FL 32832
Primary Phone: (703) 786-1060 Alternate Phone: _____

Secondary Contact: Parent/Guardian Other _____
Name: Alexander Almanza
Primary Phone: (703) 731-2232 Alternate Phone: _____

Primary Insurance Co actna Primary Group/Policy # W 2399 1 04478
Family Physician Name Dr. Austin Rulczyk Physician Phone (407) 380-1777

Please elaborate on any medical conditions of which we should be aware:
MA
Please list any medications currently being taken:
MA
In the past 24 month, have you been tested, diagnosed and/or treated for a concussion: Yes No
If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:
Please list any allergies: None
If None, please write None.

Participant Signature Sebastian Date: 1/11/19
(regardless of age):

Participant, Sebastian Almanza, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized team/RVA personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian Signature: X Michelle Lopez Date: 1/11/19
Relationship to Participant: mother

If, during the course of my daughter's/son's activities in volleyball, should she/he become ill or sustain an injury, I hereby
 AUTHORIZE or DO NOT AUTHORIZE (Select only one option to ensure validity of this document!)
you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Parent/Guardian Signature: X Michelle Lopez Date: 1/11/19

STATE OF Florida) COUNTY OF Orange)
SWORN TO BEFORE ME, a Notary Public, by said Michelle Lopez Alman personally known
to me this 11 day of January, 2019
Notary Public _____ Commission Expires 06/18/2022



Richard Pabst, Jr.
State of Florida
My Commission Expires 06/18/2022
Commission No. GG 229583



2018-2019 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. **By signing this form the participant affirms having read and agreed to the terms and conditions listed below.**

Club: Nona Sports Team Name: Nona Sports 144-B
 First Name: Leonardo Gabriel Last Name: Anglero Birth Date: 7/21/2005 Age: 13 Male Female

Primary Contact: Parent or Guardian
 Name: Leonardo Anglero Address: 10135 Shadow Creek Drive
 City, State & Zip: Orlando, FL 32832
 Primary Phone: 407-234-0323 Alternate Phone: 407-937-9810

Secondary Contact: Parent/Guardian Other
 Name: Melina E. Ramirez
 Primary Phone: 407-937-9810 Alternate Phone: 407-234-0323

Primary Insurance Co: Aetna Primary Group/Policy #: 326415-010-0000 W2397 67631
 Family Physician Name: Dr. Nielsen Physician Phone: 407-736-8733

Please elaborate on any medical conditions of which we should be aware:
ADD

Please list any medications currently being taken:
Dexamethylphenidate; Anastrozole

In the past 24 month, have you been tested, diagnosed and/or treated for a concussion: Yes No
 If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

Please list any allergies: None that I am aware of

If None, please write None.

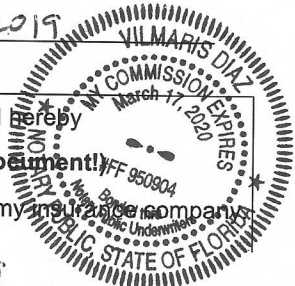
Participant Signature: Leo Anglero Date: 1/7/2019
(regardless of age):

Participant, Leonardo Gabriel Anglero, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized team/RVA personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian Signature: X [Signature] Date: 1/7/2019
 Relationship to Participant: Parent

If, during the course of my daughter's/son's activities in volleyball, should she/he become ill or sustain an injury, I hereby **AUTHORIZE** or **DO NOT AUTHORIZE** (Select only one option to ensure validity of this document) you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Parent/Guardian Signature: X [Signature] Date: 1/7/2019



STATE OF Florida) COUNTY OF Orange
 SWORN TO BEFORE ME, a Notary Public, by said personally known
 to me this 9th day of January, 2019
 Notary Public [Signature] My Commission Expires 3/17/20

2018-2019 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

Volleyball

This **must** be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. **By signing this form the participant affirms having read and agreed to the terms and conditions listed below.**

Club: LAKE NONA/Nona Sports Team Name: Boys U14/Nona Sports 174-B
 Tristan Browning 10/5/04 14 Male Female
 First Name Last Name Birth Date Age

Primary Contact: Parent or Guardian
 Name: Sarah von Braun Address: 2820 Ashbridge St
 Primary Phone: 321-287-8812 City, State & Zip: Orlando, FL 32825
 Alternate Phone: _____

Secondary Contact: Parent/Guardian Other _____
 Name: Brian Browning
 Primary Phone: 321-287-1487 Alternate Phone: _____

Primary Insurance Co: Adventhealth Primary Group/Policy #: FT1000 / 81064215803
 Family Physician Name: Center for Family Care Physician Phone: # 407-303-6830

Please elaborate on any medical conditions of which we should be aware: NA

Please list any medications currently being taken: NA

In the past 24 months, have you been tested, diagnosed and/or treated for a concussion: Yes No
 If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

Please list any allergies: NONE

If None, please write None.

Participant Signature: Tristan Browning Date: 1/24/2019
 (regardless of age): Tristan Browning

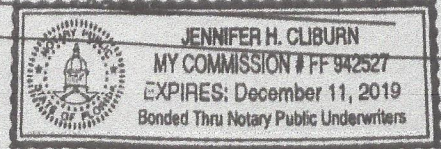
Participant, Tristan Browning, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized team/RVA personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian Signature: [Signature] Date: 1/24/2019
 Relationship to Participant: MOTHER

If, during the course of my daughter's/son's activities in volleyball, should she/he become ill or sustain an injury, I hereby **AUTHORIZE** or **DO NOT AUTHORIZE** (Select only one option to ensure validity of this document!) you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Parent/Guardian Signature: [Signature] Date: 1/24/2019

STATE OF Florida COUNTY OF Orange
 SWORN TO BEFORE ME, a Notary Public, by said Sarah Von Braun personally known
 to me this 24 day of January, 2019
 Notary Public: [Signature] My Commission Expires 12/11/19





2018-2019 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER
MEDICAL RELEASE FORM

This must be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. **By signing this form the participant affirms having read and agreed to the terms and conditions listed below.**

Club: NONA SPORTS Team Name: Nona Sports 144-B
 First Name: JAYDEN Last Name: LICONA Birth Date: 02/04/05 Age: 13 Male Female

Primary Contact: Parent or Guardian
 Name: KARLA Reyes Address: 8305 NARCOSSEE Rd.
 City, State & Zip: ORLANDO, FL 32827
 Primary Phone: (305) 975-9641 Alternate Phone: C

Secondary Contact: Parent/Guardian Other Grandmother
 Name: _____
 Primary Phone: _____ Alternate Phone: _____

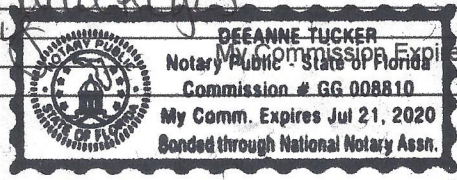
Primary Insurance Co: UNITED HEALTH CARE Primary Group/Policy #: 1
 Family Physician Name: _____ Physician Phone: _____

Please elaborate on any medical conditions of which we should be aware:
NONE / HEALTHY
 Please list any medications currently being taken:
VITAMINS
 In the past 24 month, have you been tested, diagnosed and/or treated for a concussion: Yes No
 If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:
 Please list any allergies:
If None, please write None.

Participant Signature: Jayden Licona Date: 1/10/2019
 (regardless of age):
 Participant, Jayden Licona, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized team/RVA personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.
 Parent/Guardian Signature: X [Signature] Date: 1/10/2019
 Relationship to Participant: Mother

If, during the course of my daughter's/son's activities in volleyball, should she/he become ill or sustain an injury, I hereby
 AUTHORIZE or DO NOT AUTHORIZE (Select only one option to ensure validity of this document!)
 you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.
 Parent/Guardian Signature: X [Signature] Date: 1/10/2019

STATE OF Florida COUNTY OF Orange
 SWORN TO BEFORE ME, a Notary Public, by said Karla Reyes personally known
 to me this 10th day of January, 2019
 Notary Public





2018-2019 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This must be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. By signing this form the participant affirms having read and agreed to the terms and conditions listed below.

Club: Nona Sports Team Name: Nona Sports 144-B
First Name: Fabian Last Name: MATOS Birth Date: 12/15/2005 Age: 13 Male Female

Primary Contact: Parent or Guardian
Name: ERIC MATOS Address: 10929 Arbor View BLVD
City, State & Zip: Orlando FL 32825
Primary Phone: 321.297.2847 Alternate Phone: 321.297.2846

Secondary Contact: Parent/Guardian Other
Name: DIANA OCASIO
Primary Phone: 321.297.2846 Alternate Phone: 321.297.2847

Primary Insurance Co: United Healthcare Primary Group/Policy #: 702457 1826083687
Family Physician Name: Dr Ward Physician Phone: 407.767.2477

Please elaborate on any medical conditions of which we should be aware: None
Please list any medications currently being taken: None
In the past 24 month, have you been tested, diagnosed and/or treated for a concussion: No
If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:
Please list any allergies: None
If None, please write None.

Participant Signature: Fabian Matos Date: 1/09/19
(regardless of age):

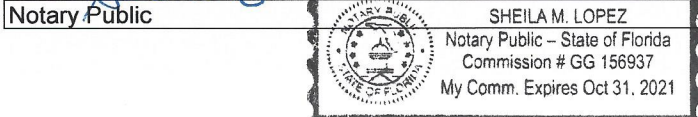
Participant, Fabian Matos, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized team/RVA personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian Signature: [Signature] Date: 1/10/19
Relationship to Participant: FATHER

If, during the course of my daughter's/son's activities in volleyball, should she/he become ill or sustain an injury, I hereby
[AUTHORIZE] or [DO NOT AUTHORIZE] (Select only one option to ensure validity of this document!)
you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Parent/Guardian Signature: X Date:

STATE OF Florida) COUNTY OF Orange)
SWORN TO BEFORE ME, a Notary Public, by said Eric Wilfredo Matos personally known
to me this 11th day of January, 2019. My Commission Expires Oct 31 2021





2018-2019 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This **must** be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. **By signing this form the participant affirms having read and agreed to the terms and conditions listed below.**

Club: Nona Sports Team Name: Nona Sports 194-B
Antonio Medina Torres 10/23/2005 13 Male Female
 First Name Last Name Birth Date Age

Primary Contact: Parent or Guardian
 Name: Wilfredo Medina Rivera Address: 11939 James Blvd
 City, State & Zip Orlando FL 32827
 Primary Phone: 407 984 2074 Alternate Phone: 407 984 2077

Secondary Contact: Parent/Guardian Other
 Name: MARIA DELA TORRES GRAYALES
 Primary Phone: 407 984 2077 Alternate Phone: _____

Primary Insurance Co _____ Primary Group/Policy # _____ / _____
 Family Physician Name _____ Physician Phone _____

Please elaborate on any medical conditions of which we should be aware:

 Please list any medications currently being taken:

 In the past 24 month, have you been tested, diagnosed and/or treated for a concussion: Yes No
 If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

 Please list any allergies:

If None, please write None.

Participant Signature [Signature] Date: 1/10/19
(regardless of age)
 Participant, Antonio J. Medina Torres, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized team/RVA personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.
 Parent/Guardian Signature: X [Signature] Date: 1/10/19
 Relationship to Participant: DAD

If, during the course of my daughter's/son's activities in volleyball, should she/he become ill or sustain an injury, I hereby
 AUTHORIZE or **DO NOT AUTHORIZE** (Select only one option to ensure validity of this document!)
 you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.
 Parent/Guardian Signature: X [Signature] Date: 1/10/19

STATE OF Florida COUNTY OF Orange
 SWORN TO BEFORE ME, a Notary Public, by said Antonio J. Medina Torres personally known
 to me this MADELEINE REVELLES day of January, 2020
 MY COMMISSION # GG023703 My Commission Expires August 23, 2020
 Notary Public EXPIRES August 23, 2020

THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.



2018-2019 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This **must** be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. **By signing this form the participant affirms having read and agreed to the terms and conditions listed below.**

Club: None Sports Team Name: None Sports 144-B
Vincent Wishart 5/6/06 12 Male Female
First Name Last Name Birth Date Age

Primary Contact: Parent or Guardian
Name: Anthony Wishart Address: 10896 Spider Lily Dr.
City, State & Zip: Orlando, FL 32832
Primary Phone: 407-403-3173 Alternate Phone: _____

Secondary Contact: Parent/Guardian Other _____
Name: Stephanie Paugh
Primary Phone: 407-297-0230 Alternate Phone: _____

Primary Insurance Co: Aetna Primary Group/Policy #: 326404-010-1 W2395 96637
Family Physician Name: Dr. Nguyen Physician Phone: 407-270-1900

Please elaborate on any medical conditions of which we should be aware:

Please list any medications currently being taken:

In the past 24 month, have you been tested, diagnosed and/or treated for a concussion: Yes No
If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

Please list any allergies:

If None, please write None.

Participant Signature: [Signature] Date: 1/10/19
(regardless of age): Vincent Wishart

Participant, Vincent Wishart, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized team/RVA personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian Signature: [Signature] Date: 1/10/19
Relationship to Participant: Father

If, during the course of my daughter's/son's activities in volleyball, should she/he become ill or sustain an injury, I hereby
 AUTHORIZE or **DO NOT AUTHORIZE** (Select only one option to ensure validity of this document!)
you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.
Parent/Guardian Signature: [Signature] Date: 1/10/19

STATE OF Florida) COUNTY OF Orange
SWORN TO BEFORE ME, a Notary Public, by said _____ personally known
to me this 10th day of January, 2019
My Commission Expires 11/20/20
Notary Public [Signature]

