2019 Florida Fest Boys' Bid Tournament

1/26/2019 - 1/27/2019

Team Nona Sports 14U-B
Club Nona Sports

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	Licona, 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 waivered 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

Signature

407-234-0323
Phone Number

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 14u-B

Alejandro (First Name) Alberti (Last Name) 6/12/06 (Birth Date) 12 (Age) ☒ Male ☐ Female

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 (regardless of age): _____ Date: _____

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: X 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: X 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 ,20 19

Notary Public My Commission Expires 2/11/2020

REBECCA DELLER
Notary Public - State of Florida
Commission # FF 959746
My Comm. Expires Feb 11, 2020

Revised 07/09/2018 MM

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

First Name	Last Name	Birth Date	Age	
Sebastian	Almanza	8/16/05	13	☒ Male ☐ Female

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: aetna Primary Group/Policy #: W2349 / 04478
Family Physician Name: Dr. Austin Rodriguez Physician Phone: (407) 380-1777

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

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 Alvarez personally known to me this 11 day of January ,20 19

Notary Public _____ Commission Expires 06/18/2022

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

Revised 07/09/2018 MM

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: Nona Sports 14u-B

Leonardo Gabriel (First Name) | Angkeró (Last Name) | 7/21/2005 (Birth Date) | 13 (Age) | ☑ Male ☐ Female

Primary Contact: Parent or Guardian
Name: Leonardo Angkeró 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: Melinna E. Ramirez
Primary Phone: 407-937-9810 Alternate Phone: 407-234-0323

Primary Insurance Co Aetna Primary Group/Policy # 326915-010-00009 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:
Dexmethylphenidate; 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 (regardless of age): Leo Angkeró Date: 1/7/2019

Participant, Leonardo Gabriel Angkeró, 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

VILMARIS DIAZ MY COMMISSION EXPIRES March 17, 2020 FF 950904 NOTARY PUBLIC STATE OF FLORIDA

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 ,20 19
Notary Public My Commission Expires 3/17/20

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: LAKE NONA/Nona Sports Team Name: BOYS U14/Nona Sports 14-B

Tristan (First Name) Browning (Last Name) 10/5/04 (Birth Date) 14 (Age) ☒ Male ☐ Female

Primary Contact: Parent or Guardian
Name: Sarah von Braun Address: 2820 Ashbridge St.
City, State & Zip Orlando, FL 32825
Primary Phone: 321.287.8812 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 / 810642158 03
Family Physician Name Center for FamilyCare Physician Phone F 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 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 (regardless of age): Tristan Browning Date: 1/24/2019

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: X [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: X [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]

JENNIFER H. CLIBURN
MY COMMISSION # FF 942527
EXPIRES: December 11, 2019
Bonded Thru Notary Public Underwriters

My Commission Expires 12/11/19

Revised 07/09/2018 MM

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: Nona Sports 14-B

JAYDEN (First Name) LICONA (Last Name) 02/04/05 (Birth Date) 13 (Age) ☑ Male ☐ Female

Primary Contact: Parent or Guardian

Name: ICARLA REYES Address: 8305 NARCOOSSEE Rd.

City, State & Zip ORLANDO, FL 32827

Primary Phone: (305)975-9641 Alternate Phone:

Secondary Contact: ☐ **Parent/Guardian** ☑ **Other** Grandmother

Name:

Primary Phone: Alternate Phone:

Primary Insurance Co UNITED HEALTH CARE Primary Group/Policy # /

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 (regardless of age): Jayden Licona Date: 1/10/2019

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 ,20 19

Notary Public

DEEANNE TUCKER
Notary Public - State of Florida
Commission # GG 008810
My Comm. Expires Jul 21, 2020
Bonded through National Notary Assn.

My Commission Expires July 21, 2020

Revised 07/09/2018 MM

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: Nona Sports 144-B

Fabian	MATOS	12/15/2005	13	☑ Male	☐ Female
First Name	Last Name	Birth Date	Age		

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 / 826083487

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

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: X _____ 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 10 day of January ,20 19

Notary Public _____ My Commission Expires Oct 31 2021

SHEILA M. LOPEZ
Notary Public – State of Florida
Commission # GG 156937
My Comm. Expires Oct 31, 2021

Revised 07/09/2018 MM

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: Nana Sports Team Name: Nana Sports 14u-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 Bar Dr
City, State & Zip Orlando FL 32827
Primary Phone: 407 984 2074 Alternate Phone: 407 984 2077

Secondary Contact: ☒ **Parent/Guardian** ☐ **Other** _____
Name: Maria De La Torres Grajales
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 (regardless of age): _____ Date: 1/10/19

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 _____ 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 _____ 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 10 day of January ,20 19

MADELEINE REVELLES
MY COMMISSION # GG023703
EXPIRES August 23, 2020

Notary Public My Commission Expires August 23, 2020

Revised 07/09/2018 MM

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: Nova Sports Team Name: Nova Sports 14u-B

Vincent (First Name) Wishart (Last Name) 5/6/06 (Birth Date) 12 (Age) ☑ Male ☐ Female

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: 407-797-0730 Alternate Phone:

Primary Insurance Co Aetna Primary Group/Policy # 326404-010-0010 / W2345 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 (regardless of age): Date: 1/10/19

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: X 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: 1/10/19

STATE OF Florida) COUNTY OF Orange)
SWORN TO BEFORE ME, a Notary Public, by said DL personally known
to me this 10th day of January ,20 19
My Commission Expires 11/20/20

Notary Public

Elaine M. Vega
NOTARY PUBLIC
STATE OF FLORIDA
Comm# GG047391
Expires 11/20/2020

Revised 07/09/2018 MM