2019 Florida Fest Boys' Bid Tournament

1/26/2019 - 1/27/2019

Team
Club

Nona Sports 14U-B

Nona Sports

Team Code Division MJ4NONAS1FL 14 Open

Jers.#/ Pos.	Name	USAV#	USAV Ver.	Birthdate	Coach Cert.	BGS Ver	SafeSport	Impact	Added
21 DS	Alberti, Alejandro	FL2986101MOJ19	Υ	06/12/06	Player	-	-	-	01/06/19
11 Middle	Almanza, Sebastian	FL3233405MOJ19	Υ	08/16/05	Player		_	ekipi keli pila sila keli kilipin sila kelilipin sila kelilipin sala pila permusukan kelilipin selat salah seb T	01/06/19
32 Middle	Anglero, Leonardo	FL2985961MOJ19	Υ	07/21/05	Player	-	_	=	01/06/19
1 Right	Browning, Tristan	FL2985139MOJ19	Υ	10/05/04	Player		e de mandre de la comitación de la completa en especial de la completa en especial de la completa en especial	na nakata nakatika masani tan pengen	01/24/19
17 Right	Licona, Jayden	FL3231766MOJ19	Υ	02/04/05	Player	-	_	40.0	01/06/19
16 Left	Matos, Fabian	FL3123598MOJ19	Υ	12/15/05	Player		and a count of the contraction o	eroon van ooders ook van de seeroon	01/06/19
7 Left	Medina, Antonio	FL2986676MOJ19	Υ	10/23/05	Player			=	01/06/19
12 Setter	Wishart, Vincent	FL2817128MOJ19	Υ	05/06/06	Player		na mata an matakan matakan matakan di kacamatan matakan mataka	Principal (1975) and the development and a final section of the se	01/06/19
Head Coach	Anglero, Leonardo	FL2458629MOA19	Υ	02/07/78	IMPACT	USAV	USAV	USAV	01/06/19
Roster size: 9	9 (8 players and 1 staf	fmembers)		** [enotes p	layer is team	captain, [W] D	enotes waiver	ed 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.

Print Name	
Print Name	Signature 70
407-234-6323	1/24/3019
Phone Number	Date



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

Club: Nona Sports	Team Name: Nova Coots 144-B
Alejando Alberti	<u>6//2/06</u> 12 ⊠Male □ Female
First Name Last Name	Bírth Óate Age
Primary Contact: Parent or Guardian Name: Laura Runa	Address: 9429 Candice Ct.
- Region	City, State & Zip Oclando, FL 32832
Primary Phone: 407-719-5183	Alternate Phone:
Secondary Contact: ☑ Parent/Guardian □Other	
Name: Jorge Alberti	
Primary Phone: 404-416-5107	Alternate Phone:
Primary Insurance Co Aztna	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 sh	ould be aware:
N/A	
Please list any medications currently being taken:	
NIA	
In the past 24 month, have you been tested, diagnosed and	l/or treated for a concussion: ☐ Yes ☒∕No
If yes, provide the date (months and year), who performed t	he testing/diagnosing/treatment and what was the outcome:
Please list any <u>allergies</u> : NONE	
If None, please write None.	
Participant Signature	Date:
(regardless of age): Participant, Alejandro E. Alberti	has my normission to norticinate in training
competition, events, activities and travel sponsored by USA Volley	has my permission to participate in training, ball or any of its Regional Volleyball Associations (RVAs). I approve
of the leaders who will be in charge of this program. I recognize the participant has full medical insurance with the company listed above the participant has the program of the program	lat the leaders are serving to the best of their ability. I certify that the
possession of authorized team/RVA personnel and that reasonable	e care will be used to keep this information confidential. Lagree to
allow the authorized adult team personnel to release this informati provider. I also certify to the best of my knowledge that the particip	on in the event of a medical emergency to a third party medical
described above.	and named hereoff to physically lit to origage in the activities
Parent/Guardian Signature: X Zaura Q. Le	upna Date: 1-10-19
Relationship to Participant:mother	0
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 financ	ial responsibility for the bills incurred through my insurance company.
Parent/Guardian Signature: 🗶 🗸 🗸 🗘	Date: 1-10-1a
STATE OF FLORING COUNTY OF	Orange)
SWORN TO BEFORE ME, a Notary Public, by said to me this day of	personally known
Notary Public Communication of the Notary Public Co	My Commission Expiresタ / II / Q ク



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

Club: Nona	Sports	Team Name	B14	
Sabastian	Almans 7a		8/16/05 13	Male □ Female
First Name	Last Name		Birth Date Age	
Primary Contact: Parent of Name:		Address: City, State & Zip	eto sidle	y Lone FL 32832
Primary Phone: 703	786-1060	Alternate Phone:		FL 32012
Secondary Contact: 📮 P	arent/Guardian 🗆 Other _			The state of the s
Name: /// A	31-2232	Alternate Phone:		
Primary Insurance Co	aetna	Primary Group/F	Policy# W 23	99 1 044 78
Family Physician Name	Dr. Anitria Rulei	Physician Phon	e (407) 3	180-1777
	edical conditions of which we	should be aware:		
Please list any medications	**			
M				
In the past 24 month, have If yes, provide the date (mo	you been tested, diagnosed a onths and year), who performe	and/or treated for a co ed the testing/diagnos	oncussion: □ Yes sing/treatment and w	⊠ No hat was the outcome:
Please list any <u>allergies</u> :	None		* 1	
If None, please write Non	4			
	Cla) har	Date:	1/11/18	
participant has full medical ins possession of authorized team allow the authorized adult tear	and travel sponsored by USA Vonarge of this program. I recognize for the company listed and that reason in personnel to release this information of the particular of the part	e that the leaders are s above. I understand an table care will be used to nation in the event of a	erving to the best of the description of the description of the description description of the description o	neir ability. I certify that the ment will be kept in the confidential. I agree to a third party medical
Parent/Guardian Signature Relationship to Participant:		2	Date:	1/19
AUTHORIZE or	ighter's/son's activities in volleybo			
you to obtain emergency medi	cal/dental care. I will assume fin			
Parent/Guardian Signature	x Mally	7	Date: ////	119
STATE OF PURCH SWORN TO BEFORE ME, a I to me this	Occupied Notary Public, by said May of Notary Public Notary Public Notary Public Notary Public Notary Notar	where lifez	.20	rsonally known
Notary Public	65/1/8	Flichard Pabls, M.C. State of Florida	ommission Expires	06/18/302)
		My Commission Expires 06/ Commission No. GG 22	18/2022 9583	Revised 07/09/2018 MM



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

Club: Nona Sports	Team Name: Nona Sports 144-13
First Name Last Name Last Name	7/21/2005 13 ☐ Male ☐ Female
Primary Contact: Parent or Guardian Name: Leonardo Anglevo	Address: 10135 Shadow Creek Drive
Primary Phone: 457-234-0323	City, State & Zip Alternate Phone: 407-937-9810
Secondary Contact: Parent/Guardian Other Name: Melinna E. Ramyrez	
Primary Phone: 457-937-9810	Alternate Phone: 407-234-0323
Family Physician Name Dr. Widsen	Primary Group/Policy # 326415-010-00034 W2397 67631 Physician Phone 407-736-6733
Please elaborate on any medical conditions of which we $A { m DD}$	
Please list any medications currently being taken:	
Dexmethylphenidate; Anastrozole	
In the past 24 month, have you been tested, diagnosed a lf yes, provide the date (months and year), who performe	nd/or treated for a concussion: ☐ Yes ☐ No d the testing/diagnosing/treatment and what was the outcome:
Please list any <u>allergies</u> : None that I am and	ere of
Participant Signature (regardless of age):	Date: 171/2019
participant has full medical insurance with the company listed all possession of authorized team/RVA personnel and that reasons	, has my permission to participate in training, leyball or any of its Regional Volleyball Associations (RVAs). I approve a that the leaders are serving to the best of their ability. I certify that the bove. I understand and agree that this document will be kept in the able care will be used to keep this information confidential. I agree to ation in the event of a medical emergency to a third party medical cipant named hereon is physically fit to engage in the activities
Parent/Guardian Signature:	Date: 17/2019 WINNING
Relationship to Participant:Powen+	- COMMISS.
you to obtain emergency medical/dental care. I will assume fina	ct only one option to ensure validity of this document!
Parent/Guardian Signature: X	Date: 1/7/2019
STATE OF	Orange personally known 20/9 My Commission Expires 3/17/20

Volleyball

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 N	ON ANONA Sports	Taom Mama	Dark	1114	Nuna SI	Dov + 144-B
Tristan	Browning	1	015/04	14	Male	□ Female
First Name	L'ast Name		Birth Date	Age		
Primary Phone: 321.28	von Graun	_Address: City, State & Zip Alternate Phone:	2820 onerd	AS o, H	Lbrid 325	lg St.
Primary Phone. 321 28	4 8810	_Alternate Phone:				
Secondary Contact: Pare Name: Brian Primary Phone: 321.	nt/Guardian □Other _ Browning 287. 1487	Alternate Phone:				
Primary Insurance Co Family Physician Name		Primary Group/F Physician Phone				0830
Please elaborate on any med	ical conditions of which we sh	nould be aware:	JA			
Please list any <u>medications</u> c	urrently being taken: NA					
In the past 24 month, have your fives, provide the date (month) Please list any <u>allergies</u> :	hs and year), who performed	d/or treated for a control the testing/diagnos	oncussion: C sing/treatmer	Yes `` it and wh	M No lat was the	e outcome:
If None, please write None.	· · · / D		1/21/6	Y 160		
possession of authorized edult team	nd travel sponsored by USA wolf- arge of this program. I recognize urance with the company listed at /RVA personnel and that reasona n personnel to release this informa- st of my knowledge that the partic	that the leaders are spove. I understand an ble care will be used attoming the event of a	serving to the to degree that the to keep this in medical emer	pest of the his docum formation	eir ability. In the actions (RV per ability). In the confidential athird part ge in the actions (RV per ability). It is a confidential athird part actions (RV per ability). It is a confidential attitude (RV per ab	As). I approve certify that the kept in the
If, during the course of my dau	ghter's/son's activities in volleybal	I, should she/he beco	ome ill or susta	ain an inju	ıry, I hereb	у
	DO NOT AUTHORIZE (Selection Cal/dental care. I will assume fina	ncial responsibility for	r the bills issue	lity of thi	s docume	nt!)
Parent/Guardian Signature:	x Auton		Date:	I/QL	agn my insi A / 201	urance company
STATE OF Florida SWORN TO BEFORE ME, a N to me this	otary Public, by said day of January	Pranse Von	Braun	,2	ersonally kr	nown
Notary Public 1	JENNIFER H. C	LIBURN	Commission E	xpires	12	1117

Bonded Thru Notary Public Underwriters

Revised 07/09/2018 MM



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 194-13 ThyDen 1 PCONA 1 PCONA Team Name: 02/04/05 /3 Male Female
First Name Last Name Birth Date Age
Primary Contact: Parent or Guardian Name: 149249 Teyes Address: 8305 N972005566 Ted. City, State & Zip ORUBNDO, FL 32327
Primary Phone: (305)975-964/ Alternate Phone:
Secondary Contact: Parent/Guardian Dother Condmother Name: Primary Phone: Alternate Phone:
Primary Insurance Co UNTO HENCH COTE 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:
VITATTINS
In the past 24 month, have you been tested, diagnosed and/or treated for a concussion: Yes No lif yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:
Please list any <u>allergies</u> :
If None, please write None.
Participant Signature (regardless of age): Participant,
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: 1/16/2019
STATE OF COUNTY

Sonded through National Notary Assn.



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: Non Sports 144-13
FADIAN MATOS	12/15/2005 (3 ☑ Male ☐ Female
First Name Last Name	Birth Date Age
Primary Contact: Parent or Guardian Name: ERIC MATOS	Address: 10929 Arbor View BLVA
Primary Phone: 321. 297. 2847	City, State & Zip Orlando Pz 32828 Alternate Phone: 321 297- 2846
Secondary Contact: Parent/Guardian Other Name: Ocasio Primary Phone: 321.257-2346	Alternate Phone: 321. 297 · 2847
Primary Insurance Co Family Physician Name Dr Ward	Primary Group/Policy # 702 457 1826083487 Physician Phone 407.747.2477
Please elaborate on <u>any medical conditions</u> of which we show the please list any <u>medications</u> currently being taken:	ould be aware:
In the past 24 month, have you been tested, diagnosed and If yes, provide the date (months and year), who performed t	/or treated for a concussion: ☐ Yes ☐ No he testing/diagnosing/treatment and what was the outcome:
Please list any <u>allergies</u> : None, please write None.	
Participant Signature Fabon Matos (regardless of age): Participant, Fabon Matos competition, events, activities and travel sponsored by USA Volley	e care will be used to keep this information confidential. I agree to on in the event of a medical emergency to a third party medical
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 finance	cial responsibility for the bills incurred through my insurance company.
Parent/Guardian Signature: 🗶	Date:
STATE OF	Orange) C Wilfredo Matos personally known ,20 19 My Commission Expires OCT 81 2021

My Comm. Expires Oct 31, 2021



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

Club: Nona Sports		Team Name	: None Sports 194-B
Antono	Medina Ton	ves	10 23 2005 13
First Name	Last Name		Birth Date Age
Primary Contact: Parent or Guardia Name: Wilfredo N	ledina Rivers	Address: City, State & Zip	11939 JAMES BAT] Orlando 71 32827
Primary Phone: 407 984 20	> 74	Alternate Phone:	407984'2077
Secondary Contact: 図-Parent/Gua Name: MAVIA DLA T Primary Phone: Цのフタタリ	orres Granales	S Alternate Phone:	
Primary Insurance Co		Primary Group/F	Policy #//
Family Physician Name		Physician Phone	e
Please elaborate on any medical cond		ould be aware:	
Please list any medications currently	being taken:		
In the past 24 month, have you been If yes, provide the date (months and)	tested, diagnosed and year), who performed to	or treated for a content of the testing/diagnos	oncussion: Yes No sing/treatment and what was the outcome:
Please list any <u>allergies</u> : If None, please write None.			
Participant Signature	•	Date: 1	1/10/19
competition, events, activities and travel s of the leaders who will be in charge of this participant has full medical insurance with possession of authorized team/RVA perso	s program. I recognize the the company listed above onnel and that reasonable If to release this information	ball or any of its Re at the leaders are s re. I understand an e care will be used to on in the event of a	has my permission to participate in training, gional Volleyball Associations (RVAs). I approve serving to the best of their ability. I certify that the d agree that this document will be kept in the to keep this information confidential. I agree to medical emergency to a third party medical is physically fit to engage in the activities
Parent/Guardian Signature: X W	Fledren		Date://10 / / 9
Relationship to Participant:	DAd		
If, during the course of my daughter's/son	s activities in volleyball,	should she/he beco	me ill or sustain an injury, I hereby
AUTHORIZE or DO NO	TAUTHORIZE (Select	only one option to	ensure validity of this document!)
you to obtain emergency medical/dental o	are. I will assume financ	ial responsibility for	the bills incurred through my insurance company.
Parent/Guardian Signature: 🗶 🙏	I Deduci		Date: 1/10/19
STATE OF FOND AC SWORN TO BEFORE ME, a Notary Public MADELEINE REVELLEGBY MY COMMISSION # GG023703 Notage Editic Expires August 23, 2020	of January		personally known ,20 Commission Expires Jugust 23, 2020



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: Name Spots 144-B
Vinceint Wishart	Male ☐ Female
First Name Last Name	Birth Date Age
Primary Contact: Parent or Guardian Name: 407-403-3173	Address: City, State & Zip Alternate Phone:
Filliary Filone.	/ mornate i merie:
Secondary Contact: Parent/Guardian Other Name: Stephanie Fangh Primary Phone: 407-797-0730	Alternate Phone: Primary Group/Policy # 3 2 6 40 4 -010 - / 10 2 3 45 46 5 7
Timary modranee oo	Tilliary Group's Gilley in the Colon Took Took
Family Physician Name Dr. Nguyth	Physician Phone 707 277 1900
Please elaborate on <u>any medical conditions</u> of which we shad a list any <u>medications</u> currently being taken:	nould be aware:
In the past 24 month, have you been tested, diagnosed an If yes, provide the date (months and year), who performed Please list any allergies:	d/or treated for a concussion: ☐ Yes ☐ No the testing/diagnosing/treatment and what was the outcome:
of the leaders who will be in charge of this program. I recognize participant has full medical insurance with the company listed ab possession of authorized team/RVA personnel and that reasonal allow the authorized adult team personnel to release this informa provider. I also certify to the best of my knowledge that the partic described above. Parent/Guardian Signature:	Date://10//
If, during the course of my daughter's/son's activities in volleybal	1
	ct only one option to ensure validity of this document!)
you to obtain emergency medical/dental care. I will assume fina	ncial responsibility for the bills incurred through my insurance company.
Parent/Guardian Signature: X	Date: 1/[0/[9
STATE OF	personally known 20 19 My Commission Expires 112020

Expires 11/20/2020