



**USA Volleyball**

www.usavolleyball.org

# Girls 2007 Arizona Region High Performance Camp Application

### PROGRAMS (check only one):

<input type="checkbox"/> Girl's USA Select (GSEL):	Girl's born in or after 1992
<input type="checkbox"/> Girl's Youth National Team (GYNT):	Girl's born in 1990 or 1991

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Parent Work Phone ( ) \_\_\_\_\_

Your email - print clearly : \_\_\_\_\_

Parent's email \_\_\_\_\_ Parent/Guardian Name : \_\_\_\_\_

*Note: When writing a "one", please emphasize the top flare and bottom underscore (1); when writing a 'zero', please write a slash through it (Ø). Your email address must be legible, that is how we communicate with you!*

Date of Birth \_\_\_\_\_

U.S. Citizen? Yes No

Year of High School Graduation \_\_\_\_\_

T-shirt size (circle) S M L XL

Club \_\_\_\_\_ Coach \_\_\_\_\_ Age Group \_\_\_\_\_

Position (either check one or identify a 1<sup>st</sup> and 2<sup>nd</sup> choice):

Setter \_\_\_\_\_ Middle \_\_\_\_\_ Leftside \_\_\_\_\_ Rightside \_\_\_\_\_ Libero \_\_\_\_\_

You must supply your Region Name and 2007 Member Number. This can be obtained from your club coach/director or directly from your USAV Region. If you are not a member or do not submit your member number, you must pay a one-time event fee of \$7.00 which is non refundable. Also, you will be required to fill out the USAV One Time Event Form at the Tryout.

USAV Member: (circle) Yes No

Region Name \_\_\_\_\_ Member Number \_\_\_\_\_

### FEES

**CAMP FEE \$225** (\$50 Non-Refundable Deposit must accompany application)

Date Received: \_\_\_\_\_ Check # \_\_\_\_\_ (payable to AZ Region)

### APPLICATION PROCESS CHECKLIST:

- Complete application and 2 page medical release form, include signature of applicant and parent.
- Include payment.
- Fax or Mail application form, medical release form and payment to:

**AZ Region of USA Volleyball**  
2105 S. 48th Street, Suite 108  
Tempe, AZ 85282

\* You will receive email confirmation only.  
If you do not receive a confirmation contact AZ Region.  
EMAIL: azvolley@qwest.net or call (602) 454-1367

**PLEASE NOTE...**Refunds will be given for withdrawing from the Camp, less the \$50.00 deposit for administrative costs.



USA Volleyball

USA VOLLEYBALL HIGH PERFORMANCE PROGRAM
TRYOUTS, CAMPS, AND TEAMS
PLAYER MEDICAL HISTORY AND RELEASE FORM

TRYOUT SITE or CAMP NAME \_\_\_\_\_

This must be completed - legibly - and signed in all areas by both the player and his or her parent or guardian.
By signing this form the participant affirms having read it.

Name \_\_\_\_\_
Last First

Birth Date Age Gender

Parent or Guardian:

Name \_\_\_\_\_

Address \_\_\_\_\_

City State Zip

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Family Physician Name \_\_\_\_\_

Signed \_\_\_\_\_
Participant

In Emergency, Contact:

Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_

Primary Group/Policy # \_\_\_\_\_

Does policy cover sport related accidents? Yes No

Physician Phone \_\_\_\_\_

Date: \_\_\_\_\_

Participant, \_\_\_\_\_, 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 also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Signed \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

To the staff:

If, during the course of my daughter's/son's activities in volleyball, she/he should become ill or sustain an injury, I hereby authorize you to obtain emergency medical/dental care.

I will assume financial responsibility for the bills incurred through my insurance company.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_
Parent or Guardian

I do not authorize emergency medical/dental care for my daughter/son.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



USA Volleyball

NAME: \_\_\_\_\_

Immunizations (please state month and year)

Tetanus \_\_\_\_\_ Polio \_\_\_\_\_ Measles (Rubella) \_\_\_\_\_

Health History

	Yes	No	Date	Please elaborate (especially on those conditions that might be aggravated)
Allergies	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Congenital problem	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Heart	_____	_____	_____	_____
Ankle Injuries	_____	_____	_____	_____
Knee Injuries	_____	_____	_____	_____
Back Injuries	_____	_____	_____	_____
Head/Neck Injuries	_____	_____	_____	_____
Shoulder Injuries	_____	_____	_____	_____
Elbow Injuries	_____	_____	_____	_____
Wrist Injuries	_____	_____	_____	_____
Hand Injuries	_____	_____	_____	_____
Finger Injuries	_____	_____	_____	_____
Other Injuries	_____	_____	_____	_____

1) Height \_\_\_\_\_ Weight \_\_\_\_\_

2) Is there any psycho-social or physical condition for which the participant is currently under professional care?

NO \_\_\_\_\_ YES \_\_\_\_\_

3) Is the participant currently taking any medications? NO \_\_\_\_\_ YES\_\_

If so, please name the drug(s), dosage and frequency needed:

\_\_\_\_\_

4) List any known allergies:

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

6) Please list any injuries the participant has suffered in the last two months:

\_\_\_\_\_

7) State special instructions to follow in case of emergency: \_\_\_\_\_

\_\_\_\_\_