

Club Age:



BIB/SHIRT#:

## 2017-18 Club Tryout/Offer Documents

7347 S. Revere Pkwy B100

Centennial, CO 80112

720-508-4333

[www.momentumvbc.com](http://www.momentumvbc.com)

Birthdate:

First Name:

Mi:

Last Name:

### POSITION:

#### Primary Position

#### Secondary Position

\_\_\_ Setter

\_\_\_ Setter

\_\_\_ Outside

\_\_\_ Outside

\_\_\_ Middle

\_\_\_ Middle

\_\_\_ Libero/DS

\_\_\_ Libero/DS

### School Team:

### Previous Club Team:

Do you wish to play  
in college?

Yes

No

Maybe

### Parents Names:

Emails:

Cell ph:

### Tryout/Offer Checklist:

\_\_\_\_\_ Register player at the Momentum website.

This can be done at [www.momentumvbc.com](http://www.momentumvbc.com) then go to Parent eSoft login.

\_\_\_\_\_ Have current RMR Membership Card or register with RMR for Summer Membership (**Players not contracted with Momentum 2016-17 season**)

*You do NOT need to bring your membership card unless you just registered for the summer*

### Upon Offer Acceptance:

\_\_\_\_\_ Complete Credit Card Release Form

\_\_\_\_\_ Complete USAV Medical Release Form

\_\_\_\_\_ **Bring a copy of the player's Birth Certificate (players new to Momentum only)**

\_\_\_\_\_ **Bring a copy of the player's current Health Insurance card**

*Bring these documents with you in the event you are offered a contract the day of tryouts*



## Credit Card Release Form 2017-18 Season

**We agree to have the club charge our credit card according to the payment schedule stipulated for this current club season on the day the payments are due.** (please see payment chart for exact dates when credit card will be charged)

Player's Name: \_\_\_\_\_

Credit Card Holder's Name: \_\_\_\_\_

Credit Card:           Master Card                                    Visa           (we DO NOT accept AmEx)

Credit Card Number: \_\_\_\_\_

Credit Card Expiration Date: \_\_\_\_\_

Security Code: \_\_\_\_\_ For Visa/MC (3 digits on back)

Billing Address:

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Card Holder's Signature of Authorization: \_\_\_\_\_

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



## 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: \_\_\_\_\_ Team Name: \_\_\_\_\_

Male  Female

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

**Primary Contact: Parent or Guardian**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City, State & Zip \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Secondary Contact:**  Parent/Guardian  Other \_\_\_\_\_

Name: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ 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 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:  
  
 If None, please write None.

Participant Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(regardless of age):

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 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. 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: \_\_\_\_\_ Date: \_\_\_\_\_  
 Relationship to Participant: \_\_\_\_\_

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.  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian

or  
 I **do not authorize** emergency medical/dental care for my daughter/son.  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian