Player Information Sheet

(Please fill out this form completely. Write legibly with ink. This form must be turned in at tryouts.)

Athlete's Name: ________________________________Birth date:________ Age:_____

Address: ____

City: ______________________Zip:____________ Home Phone: (____)___________

Athlete's Email: ____

Athlete's Cell # __________________

Mother's Information
Name: ____
Occupation: ____
Home Phone: (_____)__________________Cell Phone: (____)__________________
Work Phone: (_____)_________________ OK to contact @ work Y N
Email Address:________________________________ Include in group email list? Y N

Father's Information
Name: ____
Occupation: ____
Home Phone: (_____)__________________Cell Phone: (____)__________________
Work Phone: (_____)_________________ OK to contact @ work Y N
Email Address:________________________________ Include in group email list? Y N

With whom does the athlete reside: Mother Father Both
The party that is responsible for payment: Mother Father Both
School: ______________________________ Grade: _____ Graduation Year:________
SAT Score ____________ ACT Score ___________ Years played in school _______
Years Played Club: _________ Club Name: ____________________________________
Position(s) Played: ____
Actual Age Division: ______ Playing Age Division:_______ Team:___________
Height: ________ Weight: _______ Right or Left Handed?
Clothing Sizes: Uniform # desired: 1st choice ____ 2nd choice _____ 3rd choice ________
Uniform Jersey _____ Practice Shirt _____ Spandex _____ Knee pads _____ Warm Up Shirt _____
Warm Up Pant _____ Shoes _____

By filling out the above questions, please be aware that you are authorizing ST7 Volleyball to use information, as ST7 Training Center, LLC deems appropriate, in various publications.

PHOTO & VIDEO RELEASE FORM

AUTORIZATION TO USE: Photographs/ Internet/ Website/ Video/
Media Release/ Full Name & Statistics Form

Throughout the volleyball club season and other ST7 programs, ST7 Training Center LLC, also known as ST7 Volleyball, will be taking photos and/or videos of the athletes. We would like to include photos and videos from this club season and other ST7 programs on our website, social media pages (Instagram, Facebook and Twitter), player profile pages, and in marketing collateral such as brochures and other printed material. In addition, there may be times when local newspapers or other media would like to take photos and/or video of club activities or we may submit photo, video, and/or write-ups to these organizations.

We will also take group photos and/or video during the club season and other ST7 programs that will be available for athletes/parents to purchase during the season and may be used on our website and social media pages (Instagram, Facebook and Twitter).

If you have any question, please do not hesitate to contact Samuel Torres, ST7 Director at 786-479-8237 or Nailybeth Morales, ST7 Administrative Director at st7volleyball@gmail.com. Parents must sign this form and return with registration material at try-out or other ST7 programs.

I ____, hereby authorize ________ or do NOT authorize _________ ST7 Training Center, LLC to use, reproduce and/or publish all written and/or visual materials, including, photographs and video of my child ____.

________________________________ ________________________

Signature Date

FLORIDA AAU VOLLEYBALL PROGRAM

MEDICAL HISTORY AND RELEASE FORM

It is recommended that this form be carried with the coach during all training and competitions. Please complete **all** sections of this form. Both the player and his or her parent/guardian **must** sign in all appropriate areas. By signing this form, the participant and parent/guardian affirms they have read and understand it.

LAST NAME _______________ FIRST NAME _______________ MI _____ (CIRCLE ONE) M F

STREET ADDRESS _______________

CITY _______________ STATE _______________ ZIP CODE _______________

BIRTH DATE ___/___/___ AGE _______________ SOCIAL SECURITY NO. _______________ AAU MEMBERSHIPS NO. _______________

TEAM NAME _______________ DIVISION _______________ HEIGHT _______________ WEIGHT _______________

The Participant, _______________, has permission to participate in the AAU Junior National Volleyball Program. I certify that the participant has full medical insurance with the company listed below and is physically fit to engage in the activities of the program. I approve the leaders and coaches of this program and recognize that they will serve to the best of their ability.

MUST SIGN: _______________ Date: _______________
PARTICIPANT SIGNATURE

MUST SIGN: _______________ Relationship: _______________
PARENT/GUARDIAN SIGNATURE

Print Name: _______________ _______________ _______________
PARENT/GUARDIAN HOME PHONE WORK PHONE

STREET ADDRESS _______________ CITY _______________ STATE _______________ ZIP _______________

INSURANCE COMPANY _______________ GROUP POLICY # _______________ DOES THIS POLICY COVER SPORTS RELATED ACCIDENTS? (CIRCLE ONE) YES NO

MEDICAL RELEASE:

If my son or daughter should become ill or sustain an injury during his or her activities of the volleyball program, I hereby authorize you to obtain emergency medical/dental care.

SIGN: _______________ Date: _______________
PARENT/GUARDIAN SIGNATURE

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

SIGN: _______________ Date: _______________
PARENT/GUARDIAN SIGNATURE

MEDICAL HISTORY

	YES OR NO		DATE	PLEASE SPECIFY
ALLERGIES	Y	N	______________	___________________________________
ASTHMA	Y	N	______________	___________________________________
DIABETES	Y	N	______________	___________________________________
EPILEPSY	Y	N	______________	___________________________________
HEADACHES	Y	N	______________	___________________________________
HEART	Y	N	______________	___________________________________
KIDNEY DISEASE	Y	N	______________	___________________________________
MOTION SICKNESS	Y	N	______________	___________________________________
INJURIES:				
ANKLE	Y	N	______________	___________________________________
KNEE	Y	N	______________	___________________________________
BACK	Y	N	______________	___________________________________
HEAD/NECK	Y	N	______________	___________________________________
SHOULDER	Y	N	______________	___________________________________
ELBOW	Y	N	______________	___________________________________
WRIST	Y	N	______________	___________________________________
HAND	Y	N	______________	___________________________________
FINGER	Y	N	______________	___________________________________
OTHER	Y	N	______________	___________________________________

IMMUNIZATIONS (please state month and year):

Tetanus_____________________ Polio______________________ Measles (Rubella)______________________

Is the participant taking any medications? _____NO _______YES

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

____

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

_______NO _______YES

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

____

Elaborate on any other medical conditions:____

____

STATE OF_________________________

COUNTY OF_______________________

SWORN TO BEFORE ME, A NOTARY REPUBLIC, BY SAID______________________________PERSONALLY

KNOW TO ME THIS_________________DAY OF_____________,20____.

____NOTARY REPUBLIC

MY COMMISSION EXPIRES______________________________