VISIONARY VOLLEYBALL

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Player's Name (Please Print)

PERMISSION TO PARTICIPATE

My above named child has my/our permission to participate in the Visionary Volleyball's Summer Volleyball Skills Camps (2008). My child is in good health and able to participate in all normal volleyball tournaments and activities.

CONSENT TO TREATMENT OF A MINOR

The undersigned parent(s) or guardian of the child named above, a minor, hereby authorize the coach or substitute as he or she may designate as for the undersigned, the consent of any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor under the general or special supervision and upon the advise of any licensed physician or surgeon and to consent to any X-Ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said minor by a licensed dentist, whether such diagnosis or treatment is rendered at the office of said physician or dentist, in the hospital or otherwise.

This authorization is given prior to any diagnosis or treatment known to be in order to enable said coach or agent(s) to act effectively in an emergency situation where I can not be contacted. Should said coach or agent(s) exercise their authorized consent hereunder upon the advise of a licensed physician or surgeon or dentist, I knowingly and voluntarily exonerate and release said coach or agent(s) for Visionary Volleyball from any liability for this action.

I understand that all reasonable measures will be taken to safeguard the health and safety of my child and that I will be notified as soon as possible in case of an emergency.

This authorization shall remain effective July 18, 2008 through July 31, 2008.

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Parent/Guardian Signature

Date: __________________________

Insurance Company Name: _______________________ Group Policy #: _____________

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