



2010 Peterborough Thunder Volleyball Club (PTVC) Athlete Information

Personal Information

Name: _____ Health Card #: _____
Address: _____
City: _____ Postal Code: _____
Phone: _____ Parent's Email: _____
Birth date (dd/mm/yyyy): _____ Ht: _____
Father: _____ Phone: w) _____ h) _____ c) _____
Mother: _____ Phone: w) _____ h) _____ c) _____
Emergency Contact: _____ Relationship: _____
Phone: w) _____ h) _____
Physician's Name: _____ Phone: _____
Dentist's Name: _____ Phone: _____

Volleyball Information

School: _____ Years Played: _____
Positions: _____ Coach: _____

Please Choose Appropriate Division:

- | | |
|---|---|
| <input type="checkbox"/> Girls Under 13 (born in 1998 or after) | <input type="checkbox"/> Girls Under 15 (born in 1996 or after) |
| <input type="checkbox"/> Girls Under 14 (born in 1997 or after) | <input type="checkbox"/> Girls Under 16 (born in 1995 or after) |
| <input type="checkbox"/> Boys Under 15 (born in 1996 or after) | <input type="checkbox"/> Girls Under 18 OVA (born in 1993/94) |

For Club Use Only (To Be Filled In By Coach)

<u>Height</u>	<u>Reach</u>	<u>Block Jump</u>	<u>Spike Jump</u>	<u>Line Touch</u>	<u>Shoe Size</u>



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Medical Information

This form is designed for you. The questionnaire helps identify athletes who should have medical consent before participating with PTVC. Read all the questions carefully and answer **YES** or **NO** opposite the appropriate question. Sign and date this form at the bottom after completing it in full.

YES NO

- 1. Has your doctor ever said you have a heart condition and recommended only medically approved physical activity?
- 2. Do you have chest pain brought on by physical activity?
- 3. (a) Have you ever been treated for a head injury?
 (b) In the last year?
- 4. Do you lose consciousness or lose your balance as a result of dizziness (i.e. Epilepsy)?
- 5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity (i.e. Arthritis)?
- 6. Is your doctor currently prescribing medication for your blood pressure or heart condition (i.e. Diuretics or water pills)?
- 7. Significant present or past injury? Explain:
- 8. Chronic medical problems such as back or knee pain. Explain:
- 9. Are you aware, through your own experience or a doctor's advice, of any other reason against your exercising without medical approval?

If you answered **YES** to #3B, you are required to see a physician before participating with PTVC. Talk to your Coach if you need assistance or clarification.

Do you wear any of the following:

Corrective Lenses: ____
 Contact Lenses: ____
 Dentures or Braces: ____
 Orthopedic Braces: ____

Do you suffer from any of the following:

Recurring Headaches: ____
 Blackouts: ____
 Seizures: ____
 Chest Pain: ____

Have you had a Tetanus Shot in the last ten years? _____

Have you had a measles shot in the last ten years? _____

I (print) _____ have read and answered the Peterborough Thunder Volleyball Club Medical Information Form (see above). I certify all my answers to be true and I declare myself in good health and ready to participate within PTVC.

Parent/Guardian Signature: _____

Athlete Signature: _____ Date _____