VOLUNTEER WAIVER AND RELEASE FROM LIABILITY
(Volunteers 18 Years and Older)

I acknowledge that my volunteering to assist USA Volleyball (USAV) and/or its Regional Volleyball Association (RVA) in scouting, coaching or providing administrative services (the "Activity") may require me to perform physical exercise or other physical activities that have the potential for bodily injury, death, or property loss. With an understanding of the activities I have volunteered for, I HEREBY ASSUME ALL THE RISKS RELATED TO MY PARTICIPATION AS A USAV/RVA VOLUNTEER.

I hereby take the following action for myself, my executors, administrators, heirs, next of kin, successors and assigns: a) I WAIVE, RELEASE AND DISCHARGE from any and all claims or liabilities for death or personal injury or damages of any kind, which arise out of or relate to my participation in the Activity, THE FOLLOWING PERSONS OR ENTITIES: USA Volleyball and its Regional Volleyball Associations; National Team Coaches and Players; Official Sponsors; Volunteers and officers, directors, employees, representatives and agents of any of the above; b) I AGREE NOT TO SUE any of the persons mentioned above for any of the claims or liabilities that I have waived, released or discharged herein; and c) I INDEMNIFY AND HOLD HARMLESS the persons or entities mentioned above from any claims make or liabilities assessed against them as a result of my actions.

_____ **I HEREBY AFFIRM THAT I AM EIGHTEEN (18) YEARS OF AGE OR OLDER, I HAVE**
(INT) READ THIS DOCUMENT, AND I UNDERSTAND ITS CONTENTS.

Printed Name:_____

Signature:_____ Date:_____

MEDICAL AUTHORIZATION

In the event that I am incapacitated and cannot grant permission, I hereby authorize any licensed physician, emergency medical technician, hospital or other medical or health care facility to treat or relieve any injuries received arising out of or relating to my participation as a USAV/RVA volunteer. I authorize any such Medical Provider to perform all procedures deemed medically advisable in attempting to treat or relieve any such injuries. I consent to the administration of anesthesia as deemed advisable. I realize and appreciate that there is a possibility of complications and unforeseen consequences in any medical treatment, and I assume any such risk for and on behalf of myself.

Name: _____ Emergency Phone #: _____

Medication Allergies: _____ Blood Type: _____

Physician Name: _____ Phone #: _____

Preferred Hospital: _____ Group Medical #:_____

Signature: _____ Date:_____