York Youth Football

PO Box 411, York, Maine 03909 | www.yorkyouthfootball.com

Medical Health & Release Form

This form must be completed before your child can participate in any of the athletic programs that are offered by YORK YOUTH FOOTBALL & CHEERLEADING program. Receipt of this form indicates the parent or guardian's approval of the named child's participation. Please complete this form and have your family physician sign it before returning it. Your child WILL NOT be allowed to participate in any activities until this form is completed and signed by you, signed by a doctor and returned to YYF.

CHILDS FULL NAME: _____AGE:_____ DOB:_____

Is your child currently under the care of a physician for a chronic illness? ___ YES ___ NO
If Yes Please Explain:_____

Is your child currently taking any medications? ___ YES ___ NO
If Yes Please Explain:_____

Has your child ever experienced chest pain, felt dizzy or passed out during exercise or physical activity? ____ YES ____ NO
If Yes Please Explain:_____

Has your child ever had any bone or joint injuries (fractures, sprains/strains)? ___ YES ___ NO
If Yes Please Explain:_____

Has your child ever been knocked out? ___ YES ___ NO DATE(S): _____
If Yes Please Explain:_____

Does your child have any allergies or asthma? ___ YES ___ NO
If Yes Please Explain:_____

Has anyone in your family died suddenly due to health-related reasons at a young age? ___ YES ___ NO
If Yes Please Explain:_____

_____**has been examined in my office on** _____
(PARTICIPANTS NAME) **(DATE OF EXAM)**
and may participate in the York Youth Football program ____ WITH / ____ WITH OUT limitations.
Any limitations will be noted below.
Limitations (if applicable):_____

_____ _____
Doctor Phone

_____ _____
Signed (PHYSICIAN SIGNATURE) Date

BY SIGNING BELOW, I/WE GRANT YORK YOUTH FOOTBALL PERMISSION TO HAVE MY CHILD, _____, TO BE TREATED FOR ANY MEDICAL CONDITIONS THAT MAY ARISE DURING PRACTICE OR GAMES. I/WE ALSO GIVE PERMISSION FOR ANY OF ITS COACHES OR VOLUNTEERS TO TRANSPORT MY CHILD TO RECEIVE APPROPRIATE MEDICAL CARE SHOULD THE NEED ARISE.

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date