Trans-Valley Youth Football League
MEDICAL FORM

Participant Name / Birth date: _____

Assumption of Risk and Consent for Treatment

I understand that there is an inherent risk of injury with my participation and contact football, and that this injury may lead to permanent disability or death. In the event of routine of emergency health examinations diagnostic procedures, treatment of illness, and/or injuries, permission is herby granted to treat the athlete above by the Trans-Valley Youth Football League medical staff and or physicians associated with other community facilities as needed.

Name of Parent / Guardian: _____ Date:_____

Signature of Parent / Guardian:_____ Date:_____

Signature of Student: _____ Date: _____

Emergency Contact #:_(_____)_____

Parent

Medical Insurance Information

Indicate the status of your personal health insurance coverage. If covered, the information indicated below must be provided for all applicable policies.

_____I am not covered by a health/accident insurance policy.
_____I am covered by my own health/accident insurance policy.
_____ I am covered by my parent's health/accident insurance policy.

Health Insurance Company Name & Address: _____

_____

Group #: _____ Policy #: _____

Physician Consent

Height: _____ Weight: _____ Blood Pressure: _____

Allergies: _____

Medication student-athlete is taking: _____

Previous Medical Conditions: _____

_____

Doctor

Previous Orthopedic Conditions: _____

_____ Student-athlete cleared for all full contact physical activities (full contact football or cheerleading including stunting)

_____ Student-athlete restricted from physical activities, reason and/or conditions for clearance (if any)

Conditions for clearance (if any): _____

_____

Signature of Doctor: _____ Date: _____

(Doctor's stamp of approval also required)