

RIDGEFIELD YOUTH FOOTBALL

Medical Form & Doctor Certification

2010 SEASON

Required for all RYF Participants

DOCTOR CERTIFICATION

Player's Name _____ Grade (Fall 2010) _____

School (Fall 2010) _____ Weight _____

I HAVE EXAMINED _____ AND FIND HIM/HER PHYSICALLY FIT TO PARTICIPATE IN [] TACKLE FOOTBALL OR [] CHEERLEADING ACTIVITIES.

ADDITIONAL COMMENTS: _____

PHYSICIAN'S SIGNATURE _____ DATE _____ (must be signed after 1/1/10)

PHYSICIAN'S NAME _____ PHONE NUMBER: _____

PRINT OR STAMP

MEDICAL INFORMATION (to be completed by parent)

Allergies Yes _____ No _____ if yes, what _____

Medication _____

Chronic Conditions Yes _____ No _____

if yes, what _____

EMERGENCY CONTACT INFORMATION:

There is another page to this form which must be completed.

Important for 2010
HOLD THIS FORM – DO NOT MAIL
RYF Medical must be hand delivered the day of equipment distribution.

RIDGEFIELD YOUTH FOOTBALL

Emergency Medical Information 2010 SEASON

Required for all RYF Participants

The Following Information Will Be Used In The Event That A Parent / Legal Guardian Is Not Available. The Purpose Of This Information Is To Provide A Quick Reference For Medical Personnel Should The Need Arise. Please Fill Out This Form Completely. If A Particular Question Is Not Applicable Write "None", N/A, Or Other Appropriate Comment otherwise NONE will be assumed. If Additional Space Is Needed, Please Use The BACK Of This Form. All Information Disclosed Here Will Be Treated As Confidential. It Will Be the Responsibility Of The Parent/Legal Guardian To Notify The Participant's Coach And League Officials If Any Information Needs To Be Added, Deleted, Changed, Or Updated In Any Way. **Please Keep A Copy For Your Records.**

Participants Name: _____ Nickname: _____ Hm Phone: _____

Street Address _____ City / Town: _____ State: _____ Zip: _____

Father's Name : _____ Email: _____

Street Address _____ City / Town: _____ State: _____ Zip: _____

Employer: _____ Home Phone: _____ Wk Phone: _____ Cell: _____

Mother's Name : _____ Email: _____

Street Address _____ City / Town: _____ State: _____ Zip: _____

Employer: _____ Home Phone: _____ Wk Phone: _____ Cell: _____

Family Medical Insurance:

Carrier: _____

Group: _____

Policy#: _____

Group#: _____

ID #: _____

Family Physician:

Name : _____

Address : _____

Phone Number : _____

Alt. Phone : _____

Preferred Hospital (1) _____ (2) _____

EMERGENCY CONTACTS: (MUST HAVE AT LEAST TWO CONTACTS)

Name: _____ Phone #: _____ Relationship to Player: _____

Name: _____ Phone #: _____ Relationship to Player: _____

Please List Any Medical Conditions (Allergies, Asthma, Etc.) And Medications Being Taken By The Participant Named Above.
Please List Any Other Information You May Deem Relevant And Helpful To Emergency Medical Personnel: (Please Note If No Information Is Given And The Words "None" Or "N/A" Is Not Filled In Then, "None" Will Be Assumed.)

/WE HAVE READ, REVIEWED FOR ACCURACY, UNDERSTOOD, ACCEPTED AND AGREED TO THE ABOVE:

*Print Parent/Legal Guardian Name

*Signature Parent/Legal Guardian

*Date

*Print Parent/Legal Guardian Name

*Signature Parent/Legal Guardian

*Date

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