



Westport PAL
Medical Form & Doctor Certification

DOCTOR CERTIFICATION

Player's Name _____ Grade (Fall 201G) _____

School (Fall 201G) _____ Weight _____

I HAVE EXAMINED _____ AND FIND HIM/HER PHYSICALLY FIT TO PARTICIPATE IN PAL SPORTS ACTIVITIES.

ADDITIONAL COMMENTS:

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S NAME _____

PRINT OR STAMP

MEDICAL INFORMATION (to be completed by parent)

Allergies Yes _____ No _____ if yes, what _____

Medication _____

Chronic Conditions Yes _____ No _____ if yes, what _____

Important: This form and the Parent Consent & Waiver Forms must be completed and received or your child may be prohibited from practicing. **Online registration eliminates need for printed Parent and Waiver forms.**

**Bring Medical Form to First Practice
or Mail Completed Forms and Fee to:
Westport PAL • P.O. Box 3222• Westport, CT 06680 (see website for instructions)**