

**Medical Form & Doctor Certification
2020 **SPRING** and/or **FALL SEASON****

Required for all WYF Participants

DOCTOR CERTIFICATION

Player's Name _____ Weight _____

Spring Flag Program:
Grade (Fall 2019/20): _____

All Fall Programs:
Grade (Fall 2020/21): _____

School (Fall 2019/20) _____ School (Fall 2020/21) _____

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

ADDITIONAL COMMENTS: _____

PHYSICIAN'S SIGNATURE _____ DATE _____

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 _____

Important

HOLD THIS FORM – DO NOT MAIL

WYF Medical and Parent Consent must be hand delivered at equipment distribution or First Practice.

EMERGENCY CONTACT INFORMATION:

1) PRIMARY CONTACT: _____ RELATIONSHIP: _____

CONTACT NUMBER: _____ ALTERNATE NUMBER: _____

2) ALTERNATE CONTACT: _____ RELATIONSHIP: _____

CONTACT NUMBER: _____ ALTERNATE NUMBER: _____