Medical Form & Doctor Certification

Doctor Certification

Player's Name _____ Grade (Fall 2016) _____

School (Fall 2016) _____ 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 06880 (see website for instructions).