

**JEFFERSON COUNTY MIDGET FOOTBALL ASSOCIATION (JMFA)  
PHYSICIANS CERTIFICATION AND MEDICAL INFORMATION AND CONSENT FORM**

Player's Full Name: \_\_\_\_\_

Parent's/Guardian's Names: \_\_\_\_\_

Phone: \_\_\_\_\_

(Day) \_\_\_\_\_ (Evening) \_\_\_\_\_

Cell phone Mom Cell phone Dad

**PHYSICIAN'S CERTIFICATION: (TO BE COMPLETED BY LICENSED MEDICAL DOCTOR)**

I hereby certify that I have examined \_\_\_\_\_ and that this player was found  
physically fit to engage in football. (Player's Name -Please Print)

**Date:** \_\_\_\_\_ **Signed:** \_\_\_\_\_

Physician (must be signed by a physician)

\_\_\_\_\_  
Print Physicians Name

**NON PARENT EMERGENCY NOTIFICATION: (TO BE COMPLETED BY PARENT/GUARDIAN)**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**MEDICAL INFORMATION: (TO BE COMPLETED BY PARENT/GUARDIAN)**

Health Insurance co \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies to Medication: \_\_\_\_\_

Required Medications: \_\_\_\_\_

Additional Medical Problems: \_\_\_\_\_  
(Asthma, heart murmurs, rheumatic fever, etc.) \_\_\_\_\_

**MEDICAL TREATMENT AUTHORIZATION (OPTIONAL)**

I, \_\_\_\_\_, do hereby appoint and authorize JMFA and its designated representative as my attorney-in-fact to obtain and consent to any and all medical/dental attention and hospital care and treatment, including major surgery deemed necessary by a medical/dental provider selected by attorney-in-fact for the health and well being of \_\_\_\_\_ (Player's Name) who is participating in JMFA activities. This power expires on December 31<sup>st</sup> of this current year.

Signature of Parent/Guardian named above \_\_\_\_\_ Date \_\_\_\_\_

(The authorization is to be used if a parent or guardian can not be contacted in a timely manner in the event of a medical situation. It is entirely optional)