## Trans-Valley Youth Football League MEDICAL FORM

Participant Name:	Birthdate:
<u>Assun</u>	nption of Risk and Consent for Treatment
to permanent disability or death. In the event of	ury with my participation and contact football, and that this injury may lead f routine of emergency health examinations diagnostic procedures, treatment transed to treat the athlete above by the Trans-Valley Youth Football League other community facilities as needed.
Name of Parent / Guardian:	Date:
Signature of Parent / Guardian:	Date:
Signature of Student:	Date:
Emergency Contact #:_()	
	Medical Insurance Information
Indicate the status of your personal health insurprovided for <u>all</u> applicable policies.	rance coverage. If covered, the information indicated below <u>must</u> be
I am not covered by a health/accident in I am covered by my own health/accider I am covered by my parent's health/acc	nt insurance policy.
Health Insurance Company Name & Address: _	
Group #:	Policy #:
	Physician Consent
Height: Weight:	Blood Pressure:
Allergies:	
Medication student-athlete is taking:	
Previous Medical Conditions:	
Previous Orthopedic Conditions:	
Student-athlete cleared for all full contact	et physical activities (full contact football or cheerleading including stunting)
Student-athlete restricted from physical a	activities, reason and/or conditions for clearance (if any)
Conditions for clearance (if any):	
Signature of Doctor:	Date:

(Doctor's stamp of approval also required)