Doctor Certification & Medical Information

Doctor Certification

Player's Name ________________________________ Grade ______Year ________

School _________________________________ Weight: _________

I have examined ____ and find him/her physically fit to participate in WPAL sports activities.

ADDITIONAL COMMENTS: ____

____

____

Physician's Signature: _________________________________Date:__________

Name of Physician: ____

MEDICAL INFORMATION (to be completed by parent)

Allergies: Yes _____ No: _____ if yes,please____

____

Medications: ____

Chronic Conditions: Yes _____ No: ______ if yes, Please explain: _________________________

____

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).