YORK COUNTY YOUTH FOOTBALL ASSOCIATION

PHYSICAL FORM

2024 Season

***To Be Completed by Parent(s)**

Participant Name: ____________________________ Date of Birth: _______________________

Grade: _______________ Organization Participating with: _________________________

Home Address: ____

Name & Address of Facility Performing Physical: ____________________________________

****Please explain any "Yes" answers and understand that a "Yes" will not prevent from playing***

1. Has a healthcare provider ever denied/restricted participation in sports? **YES**____________________________

NO

2. Has participant ever had an injury such as sprain, muscle/ligament tear, broken/fractured bone that caused them to miss practice/game? **YES**____

NO

3. Has participant ever suffered from a concussion or brain injury of any type? **YES** _________________________

NO

4. Does the participant experience dizziness or headache with exercise? **YES** ______________________________

NO

Permission to Treat: I understand that signing below gives permission to have the YCYFA's EMT to treat my participant at the time of injury. I understand that the EMT is licensed and will determine the proper treatment and will also inform myself of their determination. I understand that if the EMT sends my participate to be by a physician I will need to provide a medical note clearing them to return to play.

Confidentiality: I understand that all information recorded and collected by the YCYFA and their organizations, EMTs and Officials will be held with the highest confidentiality as possible. I understand that no information will be shared with other parents, participants, or organizations.

Parent Printed Name:

____

Parent Signature: ____

Date: ____

HEALTH CERTIFICATION- To be completed by Physician- ***A Well Child Report is not considered a Physical for Football***

☐ CLEARED TO PLAY FOOTBALL ☐ Restrictions

PHYSICIAN SIGNATURE ____

PHYSICIAN PRINTED NAME ____

MEDICAL PROVIDER NO. _______________ Date of Physical: ______________