SIX RIVERS YOUTH FOOTBALL CONFERENCE, INC

SRYF PHYSICAL FORM & CONSENT

Special Note: This form must be dated after April 1st of the current year, and then submitted to your association.
No other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/or state laws or because of medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to any modified/substituted form. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.)

Section I: FOR PARENT/GUARDIAN COMPLETION ONLY

Legal Name of Participant (must match birth certificate):
Last _____First_____Middle_____
Address:_____ City:_____ State:_____Zip:_____
Telephone No:_____ Date of Birth: _____ Male____ Female ____
Name of Primary Medical Insurance Company:_____Policy Number: _____
Membership Number:_____ Name of Primary Insured: _____
Does participant have Medical? Yes Sport (check one): Cheer_____ Tackle_____

PARTICIPANT MEDICAL HISTORY

1.	Are there any injuries requiring medical attention?	Yes	No
2.	Are there any past surgeries or scheduled surgeries?	Yes	No
3.	Is there any history of concussions and/or head injuries?	Yes	No
4.	Is the participant currently under the care of a medical practitioner?	Yes	No
5.	Is the participant currently taking any medications?	Yes	No
6.	Does the participant have any allergies (penicillin, bee stings, etc)?	Yes	No
7.	Does the participant have asthma/require the use of an inhaler?	Yes	No
8.	Is the participant diabetic/require medication for diabetes?	Yes	No
9.	Does the participant carry sickle cell trait/suffer from sickle cell disease?	Yes	No
10.	Does the participant currently require medication?	Yes	No
11.	Does/has the participant have/had seizures?	Yes	No
12.	Does the participant wear glasses or contact lenses?	Yes	No
13.	Does the participant wear a brace or other medical support device?	Yes	No
14.	Does the participant have any other physical limitations or medical conditions?	Yes	No

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space and/or attach to this form:

_____
_____
_____
_____

I hereby certify that this information is accurate to the best of my knowledge. I understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore*, I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that it's my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.*

Dated:_____

Signature of Parent or Legal Guardian:_____

Print Name & Relationship to Player:_____

PHYSICAL FITNESS & MEDICAL HISTORY FORM

SIX RIVERS YOUTH
FOOTBALL CONFERENCE, INC

Section II: THIS SECTION MUST BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL ON OR AFTER APRIL 1ST of the CURRENT CALENDAR YEAR.

Name of Participant:_____

(Please check the following if healthy or note otherwise):

- Height Weight Eyes
- Ears Mouth Nose & Throat
- Respiratory Cardiovascular Neurological
- Muskoskeletal Dermatological Blood Pressure

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be involved in participating in Six Rivers Youth Football Conference, Inc, tackle football or cheer programs. I hereby swear and attest that this individual is physically fit and I have found no medical reason which would prevent this individual from safely participating in Six Rivers Youth Football Conference, Inc. activities for the 2015 season. I am therefore clearing this individual for athletic participation without limitation.

Please indicate medical profession (M.D., D.O. R.N., C.N.P, etc.)_____

Are you licensed in your state to perform physical examinations? YES NO

Dated: _____

Please sign and fill out the following information OR place Official Medical Practice Stamp here:

Signature:_____Printed Name:_____

Address:_____City_____State:_____ Zip:_____

Phone: _____ Fax: _____

Email/Website: Email:_____ (Optional)

Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc. – this may vary by state). NO other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/or state laws OR because of medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to any modified/substituted form that MUST be signed on or after April 1st of the current year.