

WILLAMETTE VALLEY YOUTH FOOTBALL & CHEER

rev. 4/22/2024

**Special Note:** This form must be submitted to your LOCALWVYFC association. It is valid for a **maximum of two seasons and cannot expire during the football season.** If any medical information changes, a new form must be submitted. 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 (e.g.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

Address: City:

Telephone: Date of Birth:

Name of Primary Medical Insurance Company:

Membership Number: Name of Primary Insured:

Middle

State: Zip:

Male Female Policy Number:

Does primary insured have Medicaid? **O** Yes **O** No Does primary insured have Medicare? **O** Yes **O** No **Sport (check one): O Cheer O Tackle Football**

### PARTICIPANT MEDICAL HISTORY

1. Are there any injuries requiring medical attention? **O** YES **O** NO
2. Are there any past surgeries or scheduled surgeries? **O** YES **O** NO
3. Is there any history of concussions and/or head injuries? **O** YES **O** NO

4. Is the participant currently under the care of a medical practitioner? **O** YES **O** NO 5. Is the participant currently taking any medications? **O** YES **O** NO

6. Does the participant have any allergies (penicillin, bee stings, etc)? **O** YES **O** NO

7. Does the participant have asthma/require the use of an inhaler? **O** YES **O** NO

8. Is the participant diabetic/require medication for diabetes? **O** YES **O** NO

9. Does the participant carry sickle cell trait/suffer from sickle cell disease? **O** YES **O** NO l0. Does the participant currently require medication? **O** YES **O** NO

1. Does/has the participant have/had seizures? **O** YES **O** NO
2. Does the participant wear glasses or contact lenses? **O** YES **O** NO
3. Does the participant wear a brace or other medical support device? **O** YES **O** NO

15. Does the participant have any other physical limitations or medical conditions? **O** YES **O** 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 acknowl- edge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condi- tion of my child. I also understand that it is 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.

Signature of Parent or Legal Guardian:

Print Name

Relationship to Participant Dated

WILLAMETTE VALLEY YOUTH FOOTBALL & CHEER

# SECTION II: THIS SECTION MUST BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL.

## 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 licenced state examiner and have examined the above named individual and understand that he/she will be involved in partieipating in Willamette Valley Youth Football & Cheer. I hereby swear and attest that this in- dividual is physically fit and I have found no medical reaeon which would prevent this individual from safely participating in WVYFC activities for the 2024 season. I am, therefore, clearing this individual for athletie participation without limitation.

Please indicate medical profession (M.D., D.O. R.N., etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

# **Please sign and fill out (or stamp) the following medical practice information:**

# Medical Practice\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip

## Phone Email/Website:(Optional)

Name Signature Date

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 in the current calendar year. SECTION II pyhsical is valid for two seasons from date signed and cannot expire during the football season (1 September – 30 November).