

SIX RIVERS YOUTH FOOTBALL CONFERENCE

PHYSICAL FORM

NAME OF PLAYER/CHEERLEADER: _____ DOB: _____
PLEASE INDICATE EXISTING PHYSICAL/MEDIAL PROBLEMS, MEDICINES BEING TAKEN, OR
TREATMENT BEING RECEIVED: _____

PHYSICAL FINDING(TO BE COMPLETED BY MEDICAL PERSONNEL):

HEIGHT: _____ WEIGHT: _____ PULSE: _____ B.P: _____ / _____ VISION: _____
HEAD AND NECK: _____

CHEST,HEART AND LUNGS: _____

ABDOMEN: _____

EXTREMITIES: _____

I CERTIFY THIS INDIVIDUAL IS FIT TO PLAY TACKLE FOOTBALL OR CHEERLEAD AS INDICATED:

*DOCTOR'S SIGNATURE: _____ M.D

*MEDICAL PERSONNEL: _____

*LICENSE#: _____

*PHONE: _____

*ADDRESS: _____

*DATE: _____

SECTION IV-PARENTAL CONSENT, RELEASE AND MEDICAL TREATMENT AUTHORIZATION

We the parent(s)/guardian(s) of the candidate named herein, do hereby give my/our approval for al participation in this SRYF activities for the current season. I/We assume all risks and hazards to this participation for any claims arising out of injury to My/Our child, including but not limited to transportation to and from such activities. I/We hereby waive, release, absolve, indemnify and agree to hold harmless, the conference/League, local team, organizers, sponsors, managers, coaches, supervisors, participants, persons providing transportation, and any organization this SRYF program may be affiliated with.

The SRYF Conference has acquired Accident-Medical Blanket Team Insurance Group Coverage at no cost to the candidate provided by the parent(s)/guardian(s) own personal and/or employee*s dependent group insurance. The SRYF Conference Accident Medical Insurance coverage provides for each injury incurred, subject to a deductible of \$100.00, a maximum Medical benefit of \$3,000.00 and a maximum Dental benefit of \$250.00 to natural teeth; providing medical/dental treatment commence within 60 days from date of injury and such treatment is required by an attending physician. Abdominal hernia, illness/disease and pre-existing conditions are not covered.

In executing the foregoing release I/We understand any claims for injury arising out of My/Our child's participation, must be reported to the Team Official within 30 days of injury; I/we understand the Proof of Loss forms must be completed in full and filed within 60 days of mailing; I/we understand any monies I/We paid to the team, does not constitute payment of insurance coverage; I/We do Indemnify the SRYF Conference and the Insurance Carrier should there be statement(s) by anyone that is in contradiction; I/We certify I/We can receive a copy of the Contract and the disclosure information upon request; I/We have read and understand fully, the provisions of this Consent/Release/Authorization, and I/We have signed it voluntarily.

FURTHER, I/We hereby grand authority to a qualified doctor of medicine or physician to render such medical treatment as said Doctor or Physician deems necessary under the circumstances.

MY/OUR EMPLOYMENT GROUP/INSURANCE CO. IS:

#/POLICY#/MEDI-CAL#:

DATE: _____

PARENT/GUARDIAN PRINTED NAME

PARENT/GUARDIAN SIGNATURE