



AMERICAN YOUTH FOOTBALL

Medical Clearance Form



ASSOCIATION NAME - _____

Medical Clearance Form - Must be dated after January 1st of the Current Season

I, hereby my signature below, do certify that I am licensed by the state and am qualified in determining that: (Childs Name:) _____ is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating in youth flag football, tackle football, cheer, dance, step or athletic activities. I am therefore clearing this individual for athletic participation.

<div style="margin-bottom: 10px;"> } _____ <i>Signature:</i> </div> <div style="margin-bottom: 10px;"> } Date: ____ / ____ / ____ <i>(Must be dated after January 1st, of the Current Season)</i> </div>	<p style="text-align: center;"><i>Please Print - or - Use Office Stamp Here:</i></p> <div style="margin-bottom: 10px;"> _____ Print Name Clearly: </div> <div style="margin-bottom: 10px;"> _____ Office Address: </div>
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PLEASE NOTE: If this Medical Clearance is voided by injury, accident, or illness, it will be the responsibility of the Parent/Legal Guardian to notify the participants Coach and League Officials. It will also be the responsibility of the Parent / Legal Guardian to obtain WRITTEN permission from his/her physician to resume participation. A "Doctors Resume Participation Medical Clearance Form" is available from the league or you may have the doctor supply his/her own WRITTEN Clearance as long as it is on the doctor's official stationery and includes the following statement: "(Participants Name) is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating in youth flag football, tackle football, cheer, dance, step or athletic activities. I am therefore clearing this individual for athletic participation."

POWERED BY:

This statement must be supplied by the physician attending to the injury, accident, or illness.

This form can be modified or substituted ONLY to comply with local and/or state laws or due to medical practitioner regulations.

NOTE: This form as with any and all forms used by your Association should be reviewed by your local counsel for compliance with any state or local statutes. This form should be kept on file for a minimum of 7 years, longer in the event of an injury. Please confer with your local attorney for advice as to the appropriate maintenance and storage term for this and all such forms.

Torrington Warriors COVID-19

Self-screening Form

To protect all members of our football family, all coaches and athletes participating in the 2021 season are required to self-screen for any observable illness, including cough or respiratory distress and to confirm temperature below 100 degrees Fahrenheit. The coach must verify that each participant has self-screened daily upon arrival. This form must be completed and turned in prior to each workout.

Date: _____

Fever or Chills: Yes No

Cough: Yes No

Nasal Congestion or Runny Nose: Yes No

Muscle or Body Aches: Yes No

Sore Throat: Yes No

Shortness of Breath or Difficulty Breathing: Yes No

Diarrhea: Yes No

New Loss of Taste or Smell: Yes No

Nausea or Vomiting: Yes No

Fatigue: Yes No

Headache: Yes No

Temperature if higher than 100.3 _____

Player Name: _____

Parent Signature: _____



**American Youth Football and Cheer, Inc.
Mild Traumatic Brain Injury (MTBI) / Concussion
Annual Statement and Acknowledgement Form**

I, _____ (athlete), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the organizations staff (e.g., coaches, team physicians, and athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My organization has provided me with specific educational materials including the CDC Concussion fact sheet (<http://www.cdc.gov/concussion>) on what a concussion is and has given me an opportunity to ask questions. FACT sheets are different for Parents, Coaches, Players.
- I ACKNOWLEDGE THAT I HAVE READ THE FACT SHEET on the CDC website for Parents and Players.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician, athletic trainer, coach, parent volunteer, or official.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spirit line, wrestling, lacrosse, mixed martial arts, and rugby and cheer.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

Print Name: _____ Signature: _____

Date: _____

Parent or legal guardian must print and sign name below and indicate date signed.

Print Name: _____ Signature: _____

Date: _____

Emergency Medical Treatment, Consent and Information

The following information will be used in the event that a parent / legal guardian is not available. The purpose of this information is to provide a quick reference for medical personnel should the need arise. Please fill out this form completely. If a particular question is not applicable write "none", n/a, or other appropriate comment otherwise none will be assumed. If additional space is needed, please use the back of this form. All information disclosed here will be treated as confidential. It will be the responsibility of the parent/legal guardian to notify the participants coach and league/event officials if any information needs to be added, deleted, changed, or updated in any way.

ATHLETE INFORMATION				
Athlete's Name:		Nick Name:		Phone: ()
Address:		City:		State: Zip:
PARENT OR GUARDIAN INFORMATION				
Father's Name:				
Address:		City:		State: Zip:
Hm Phone: ()	Daytime Phone: ()	Email:		
Employer:				
Mother's Name:				
Address:		City:		State: Zip:
Hm Phone: ()	Daytime Phone: ()	Email:		
Employer:				
Guardian's Name:				
Address:		City:		State: Zip:
Hm Phone: ()	Daytime Phone: ()	Email:		
Employer:				
FAMILY MEDICAL INSURANCE				
Carrier:		Group:		
Policy #:		Group #:		
Policy Holder Name:				
Family Physician's Name:				
Dr's Address:		City:		State: Zip:
Phone: ()	Fax: ()	Email:		
EMERGENCY MEDICAL INFORMATION				
Preferred Hospital(s):				
EMERGENCY CONTACT:		Phone: ()		Relationship:
Please list any medical conditions (allergies, asthma, etc.) And medications being taken by the participant named above. Please list any other information you may deem relevant, and helpful to emergency medical personnel: (please note if no information is given and the words "none" or "n/a" is not filled in then, "none" will be assumed.				
Allergies:				
Medical Conditions:				
Other:				

*I Hereby my signature grant permission for my child/ward to participate in any and all, _____ (Association name) and, American Youth Football, Inc / American Youth Cheer dba, program(s) sanctioned event(s), be they official or un official, including but not limited to, athletic, social and/or fundraising activities. I further hereby consent to any and all health care providers, authorize any first aid, emergency treatment, including but not limited to transportation to and from health care facilities and/or any medical professional to provide treatment, order injections, hospitalize, give anesthesia or perform surgery. I understand that this authorization is given prior to any need for medical care, but given to avoid unnecessary delay in emergency treatment which the attendant and/or medical professional may deem advisable in the exercise of best judgment. I presume a reasonable attempt was made to contact me.

*Print Parent/Legal Guardian Name

*Signature Parent/Legal Guardian

*Date

The original Emergency Medical Treatment, Consent and Information form should travel with the coach and a copy should be kept at the administrative office of the sports organization. Due to privacy concerns, completed forms should be stored in a secure location with access restricted to those on a need to know basis for the purpose of medical care.