

YORK COUNTY YOUTH FOOTBALL ASSOCIATION

PHYSICAL FORM

2026 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, EMT's 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: \_\_\_\_\_