JEFFERSON COUNTY YOUTH FOOTBALL ASSOCIATION (JYFA)
PHYSICIANS CERTIFICATION AND MEDICAL INFORMATION AND CONSENT FORM

Player's Full Name: ____________________

Parent's/Guardian's Names: ____________________ ____________________

Phone: ____________________ ____________________

(Day) (Evening)

____________________ ____________________

Cell phone Mom Cell phone Dad

PHYSICIAN'S CERTIFICATION: (TO BE COMPLETED BY LICENSED MEDICAL DOCTOR)

I hereby certify that I have examined ____________________ **and that this player was found physically fit to engage in football.**

(Player's Name -Please Print)

Date: ____________________ **Signed:** ____________________

Physician (must be signed by a physician)

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Print Physicians Name

NON PARENT EMERGENCY NOTIFICATION: (TO BE COMPLETED BY PARENT/GUARDIAN)

Name: ____________________

Relationship: ____________________

Phone: ____________________

MEDICAL INFORMATION: (TO BE COMPLETED BY PARENT/GUARDIAN)

Health Insurance co ____________________ Policy # ____________________

Allergies to Medication: ____________________

Required Medications: ____________________

Additional Medical Problems: ____________________

(Asthma, heart murmurs, rheumatic fever, etc.) ____________________

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MEDICAL TREATMENT AUTHORIZATION (OPTIONAL)

I ,____________________,do hereby appoint and authorize JYFA and its designated representative as my attorney-in-fact to obtain and consent to any and all medical/dental attention and hospital care and treatment, including major surgery deemed necessary by a medical/dental provider selected by attorney-in-fact for the health and well being of ____________________(Player's Name) who is participating in JYFA activities. This power expires on December 31st of this current year.

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Signature of Parent/Guardian named above Date

(The authorization is to be used if a parent or guardian can not be contacted in a timely manner in the event of a medical situation. It is entirely optional)

JYFA