YORK COUNTY YOUTH FOOTBALL ASSOCIATION
PHYSICAL FORM

2024 SEASON

* To be completed by parent(s) *

Participant Name: _____ DOB: _____

Grade: _____ Organization Participating With: York Suburban Football Club

Home Address: _____

Name & Address of Facility Performing Physical: _____

**** Please explain any "yes" answers and understand that a "yes" will not prevent player from playing ****

1. Has a healthcare provider ever denied/restricted participation in Sports?

   YES _____

   NO

2. Has participant ever had an injury 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 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 participant to be seen 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 YCYCA and their organizations, EMTS & 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 Health Care Provider

CLEARED TO PLAY FOOTBALL: YES NO

RESTRICTIONS: _____

Physician Printed Name: _____

Physician Signature: _____

Medical Provider No: _____ Date of Physical Exam: _____