YORK COUNTY YOUTH FOOTBALL ASSOCIATION

PHYSICAL FORM

2025 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, EMTs 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: _____