



# NYFL MEDICAL FORM

Participant Name / Birth date: \_\_\_\_\_

### Assumption of Risk and Consent for Treatment

I understand that there is an inherent risk of injury with my participation and contact football, and that this injury may lead to permanent disability or death. In the event of routine of emergency health examinations diagnostic procedures, treatment of illness, and/or injuries, permission is hereby granted to treat the athlete above by the NYFL, medical staff, physicians associated with other community facilities as needed.

Name of Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_ Emergency Contact # (\_\_\_\_) \_\_\_\_\_

### Medical Insurance Information

Indicate the status of your personal health insurance coverage. If covered, the information indicated below must be provided for all applicable policies.

- I am not covered by a health/accident insurance policy.
- I am covered by my own health/accident insurance policy.
- I am covered by my parent's health/accident insurance policy.

Health Insurance Company Name & Address:

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

### Physician Consent

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Allergies:

Medication student-athlete is taking:

\_\_\_\_\_

Previous Medical Conditions:

Previous Orthopedic Conditions:

Student-athlete cleared for all full contact physical activities (full contact football)

Student-athlete restricted from physical activities, reason and/or conditions for clearance (if any)

Conditions for clearance (if any):

Signature of Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ (Doctor's stamp of approval also required)