

FIELDCREST YOUTH FOOTBALL - Medical Release Form

Name: _____ Date: _____

Height: _____ Weight: _____ Birth date: _____

Allergy Alert: _____

Current Medications: _____

Dosage: _____ Frequency: _____

Physician's Name & Address: _____

Physician's Phone: _____

Hospital Preference: _____

Circle 'Yes' or 'No'. If 'yes', explain in the REMARKS section below:

YES NO Asthma

YES NO Diabetes

YES NO Epilepsy

YES NO Wears Contacts?

YES NO Birth Defects

YES NO Wears Glasses?

YES NO Swollen or Painful Joints

YES NO Wears Oral Retainer/
mouth piece?

YES NO Head Injury

YES NO Back Trouble

YES NO Neck Trouble

YES NO Knee Trouble

YES NO Broken Bones

YES NO Any Past Trauma

YES NO Any Medical Problems we should know about

Remarks:

Person to Notify in Case of Emergency: _____

Phone # _____

Parent's Signature: _____