# CENTRAL VALLEY YOUTH FOOTBALL AND CHEER
# 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 in contact sports, 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 league medical staff, physicians associated with other community facilities as needed.

Signature of Parent / Guardian: _____

Print Name of Parent / Guardian: _____ 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: _____

_____

_____ Student-athlete cleared for all full contact physical activities
_____ Student-athlete restricted from physical activities, reason and/or conditions for

Clearance (if any): _____

_____

Conditions for clearance (if any): _____

_____

Date: _____ **DOCTOR'S ADDRESS STAMP**

Signature of Doctor: _____