

**Medical Form & Doctor
Certification 2025 SPRING and/or
FALL SEASON**
Required for all WYF Participants

DOCTOR CERTIFICATION

Player's Name _____ Weight _____

Spring Flag Program:

Grade (Spring 2025): _____

All Fall Programs:

Grade (Fall 2025): _____

School (Spring 2025) _____ School (Fall 2025) _____

**I HAVE EXAMINED _____ AND FIND HIM/HER PHYSICALLY FIT TO
PARTICIPATE IN TACKLE FOOTBALL, FLAG FOOTBALL OR CHEERLEADING ACTIVITIES.**

ADDITIONAL COMMENTS: _____

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S NAME _____ PHONE NUMBER: _____

PRINT OR STAMP

MEDICAL INFORMATION (to be completed by parent)

Allergies Yes _____ No _____ if yes, what _____

Medication _____

Chronic Conditions Yes _____ No _____

if yes, what _____

Important

WYF Medical and Doctor Consent form must be submitted online to Finish the Registration Process.

EMERGENCY CONTACT INFORMATION:

1) PRIMARY CONTACT: _____ RELATIONSHIP: _____

CONTACT NUMBER: _____ ALTERNATE NUMBER: _____

2) ALTERNATE CONTACT: _____ RELATIONSHIP: _____

CONTACT NUMBER: _____ ALTERNATE NUMBER: _____