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

DOCTOR CERTIFICATION

Player's Name _____. _____Weight _____

Spring Flag Program: All Fall Programs:
Grade (Spring 2025): _____ 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: _____

_____

PHYSICAN'S SIGNATURE_____DATE_____

PHYSICAN'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
HOLD THIS FORM – DO NOT MAIL
WYF Medical and Parent Consent must be hand delivered at equipment distribution or First Practice.

EMERGENCY CONTACT INFORMATION:

1) PRIMARY CONTACT: _____ RELATIONSHIP: _____

CONTACT NUMBER:_____ ALTERNATE NUMBER: _____

2) ALTERNATE CONTACT: _____ RELATIONSHIP: _____

CONTACT NUMBER:_____ ALTERNATE NUMBER: _____