New Hampshire Youth Football & Spirit Conference

Medical Release Form

THIS FORM MUST BE COMPLETED AND SIGNED AFTER JANUARY 1ST OF CURRENT YEAR

Name: _____ Age: _____
FIRST M.I. LAST

Address: _____
STREET CITY STATE ZIP

Telephone: _____ Sport (Circle One): FOOTBALL CHEER

Does your child have any condition that may prevent participation in strenuous exercise for 6 - 10 hrs a week through the duration of the season? (Circle One) Y N
If yes, describe the condition(s)?_____

Is your child taking any medication? (Circle One) Y N
If Yes, Describe:_____

Does your child have asthma, or any other respiratory condition? (Circle One) Y N
If Yes, is your child using an inhaler? Y N Frequency Of Use:_____

Does your child have any speech, hearing or sight impairment which might have an affect on their participation in the program? (Circle One) Y N
If Yes, describe:_____

Does your child wear glasses or contacts during practice and game situations? (Circle One) Y N

Does your child have any allergies? (Circle One) Y N If Yes, what are they?_____

Has your child ever been told not to participate in any sport for medical reasons? (Circle One) Y N
If Yes, describe:_____

Do the Bedford Jaguars/NHYFSC/AYF have your permission to use your child's name and photography on their official web sites, by the local media, in both print or broadcast, for the purpose of sole purpose of publicizing any or all of these specified organizations (Circle one) Y N

Do you authorize Coaches to apply Bug Spray as needed (Circle one) Y N

Do you authorize Coaches to apply Sun Screen as needed (Circle one) Y N

Parent/Guardian Signature:_____ Date:_____

PHYSICAL RELEASE SECTION

All Lines In This Section Are Mandatory And Must Be Completed By The Doctor's Office

Date Of Child's Last Physical: _____

I state that the child named on this form is physically fit, and there are no observable conditions which would contraindicate his/her playing football/cheerleading.

Physician's Signature: _____ **Date:** _____

Please Use Office Stamp, Or Print Address On the Lines Provided Below:

Physician's Office Address: _____
Street City State Zip

Physician Telephone No.: