XTREME YOUTH FOOTBALL CONFERENCE

SECTION VI:

This form satisfies Section V of the Player Season Contract. This form **MUST BE COMPLETED BY** a Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), Nurse Practitioner or Physician's Assistant as described in Rules, Article III, Section C, Certification #3.

XYFC CHAPTER _____ **DIVISION:** ☐6U ☐7U ☐8U ☐9U ☐10U ☐11U ☐12U ☐13U ☐14U

ACTIVITY: ☐ *CHEER* ☐ *FOOTBALL*

CANDIDATE'S NAME: _____ **BIRTH DATE:** _____ **TELEPHONE:** _____
(LAST, FIRST, MI) *(BEST CONTACT)*

ADDRESS: _____ **CITY:** _____ ,CA **ZIP CODE:** _____

PHYSICIAN NAME: _____ **PHYSICIAN'S TELEPHONE:** _____

The candidate mentioned above has my/our permission to participate in XYFC activities and has permission to travel with the XYFC and Local Chapter Associations. In case of any injury, a XYFC or Local Chapter Official is authorized to have him/her treated and/or hospitalized by any doctor or facilities cooperating with XYFC or Local Chapter, and will not hold XYFC or Local Chapter and Associations responsible for payment as a result of any accident or injury.

MEDICAL HISTORY: (*TO BE COMPLETED BY PARENT/GUARDIAN*)

☐ RIGHT HANDED ☐ LEFT HANDED? **ALLERGIES TO MEDICATION:** _____

HAS THE CANDIDATE HAD ANY OF THE FOLLOWING:	(*PLEASE CHECK ALL BOXES*)		**IF "*YES*" PLEASE EXPLAIN**
1. Injuries to HEAD, NECK, SPINE, or BONES/JOINTS?	☐ YES	☐ NO	
2. Any other injuries requiring medical attention?	☐ YES	☐ NO	
3. Seizures, blackouts, or dizziness?	☐ YES	☐ NO	
4. Heart issues, heart murmur, high blood pressure?	☐ YES	☐ NO	
5. Any serious infectious diseases?	☐ YES	☐ NO	
6. Hospitalizations or any surgeries?	☐ YES	☐ NO	
7. Stomach, intestinal, or urinary tract issues?	☐ YES	☐ NO	
8. Is the candidate under the care of a doctor currently?	☐ YES	☐ NO	
9. Are there any medications prescribed for daily use?	☐ YES	☐ NO	
10. Any dental issues?	☐ YES	☐ NO	

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PHYSICAL EXAMINATION (*TO BE COMPLETED BY PHYSICIAN*) **DATE OF PHYSICAL:** _____

HEIGHT:		**HEART:**	
WEIGHT:		**LUNGS:**	
PULSE:		**CHEST:**	
BLOOD PRESSEURE:		**ABDOMEN:**	
GENERAL APPERANCE:		**BACK & EXTREMITIES:**	
HEAD & NECK:		**DERMIS:**	
NEUROLOGY:		**ANY OTHER CONCERNS:**	

From the above evaluation and physical exam, in my opinion, the mentioned candidate is physically able to participate in XYFC or Local Chapter

☐ ☐

Is further consultation necessary? ☐ **YES** ☐ **NO** **EXPLANATION:** _____

DOCTOR'S OFFICE STAMP OR SEAL

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

_____ _____
CHAPTER AD OFFICAL **DATE**