YORK COUNTY YOUTH FOOTBALL ASSOCIATION

PHYSICAL FORM

2024 Season

*To Be Completed by Parent(s)

Participant Name:	Date of Birth:
Grade: Org:	anization Participating with:
Home Address:	
Name & Address of Facility Performing Ph	nysical:
*Please explain any "Yes" at	nswers and understand that a "Yes" will not prevent from playing
1. Has a healthcare provider ever denied/re	estricted participation in sports? YES
	NO
2. Has participant ever had an injury such a miss practice/game? YES	s sprain, muscle/ligament tear, broken/fractured bone that caused them to
NO	
3. Has participant ever suffered from a con	cussion or brain injury of any type? YES
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4. Does the participant experience dizzines	s or headache with exercise? YES
at the time of injury. I understand that the	ing below gives permission to have the YCYFA's EMT to treat my participant EMT is licensed and will determine the proper treatment and will also inform I that if the EMT sends my participate to be by a physician I will need to urn to play.
	nation recorded and collected by the YCYFA and their organizations, EMTs confidentiality as possible. I understand that no information will be shared ations.
Parent Printed Name:	
Parent Signature:	
Date:	
CLEARED TO PLAY FOOTBAI PHYSICIAN SIGNATURE PHYSICIAN PRINTED NAME	e completed by Physician- A Well Child Report is not considered a Physical for Football L Restrictions Date of Physical: