

DOCTORS NOTE & CONSENT FORM

ASSOCIATION NAME: **BALD EAGLE AREA YOUTH FOOTBALL & CHEER ASSOCIATION**

NAME: _____ **WEIGHT:** _____

Physician: I hereby certify that I have examined the above named Athlete and found he/she is physically able to participate in:

FOOTBALL **CHEERLEADING**

This note is good for the 2009 school year, unless voided by serious injury, accident or illness. If void, it will be the responsibility of the child's parent/guardian to get updated medical information from his or her physician before resuming participation in sports.

PHYSICIAN NAME (printed)

PHYSICIAN SIGNATURE

DATE _____

(Physician please print address or use office stamp here)

..... Association cut here to separate these forms - Doctors Note attaches to back of contract - Consent Form given to head coach of child's team.....

INFORMED CONSENT

CHILD'S NAME

ORGANIZATION NAME

BEA YOUTH FOOTBALL & CHEER ASSOCIATION

I REALIZE THAT THERE IS A RISK OF BEING INJURED THAT IS INHERENT IN ALL SPORTS. Having read this statement and knowing the risks, I parent/guardian of the above name child do hereby give my approval of his/her participation in any and all of the activities supervised by the above named organization during the current season. I assume all risks and hazards incidental to the conduct of the activities. I further release, absolve, indemnify, and hold harmless The Bald Eagle Area Youth Football and Cheer Association, the organizers, the sponsors and the supervisors or any of the supervisors appointed by them.

Parent/Guardian Signature: _____ **Date:** _____

EMERGENCY MEDICAL INFORMATION

Your child's coach will use the following information in the event that a parent/guardian is not available during a practice or a game. Please complete the following information and see your child's coach during the year if any information needs to be updated. Contact priority will be the *FIRST* emergency name, if unavailable; the *SECOND* emergency person will then be contacted.

Athletes Address: _____ City and Zip: _____
1ST Contact: _____ 1st Phone #: _____ 2nd Phone #: _____
2ND Contact: _____ 1st Phone #: _____ 2nd Phone #: _____
Family Doctor/Clinic: _____ Phone #: _____
Preferred Hospital: _____
Health Insurance Company: _____ Policy #: _____

I hereby give permission to any member of the Bald Eagle Area Youth Football and Cheerleading to seek medical assistance for my child, and I further authorize any qualified person and/or medical facility to administer any necessary medical treatment to my child. My son/daughter has the following medical conditions (allergies, asthma, etc.) Medication being taken, and/or any other information that may be helpful to emergency medical personnel:

Signature _____ **Date** _____