



MARYLAND RAZORBACKS YOUTH FOOTBALL/CHEER PROGRAM
MEDICAL FORM

PART I – MEDICAL CONSENT

Participant Name / Birth date: _____

Assumption of Risk and Consent for Treatment

I understand that there is an inherent risk of injury with my participation in contact football, and that this injury may lead to permanent disability. In the event of routine of emergency health examinations diagnostic procedures, treatment of illness, and/or injuries, permission is hereby granted to treat the athlete above by the Maryland Razorbacks medical staff, physicians associated with other community facilities as needed.

Name of Parent / Guardian: _____ Date: _____

Signature of Parent / Guardian: _____ Date: _____

Signature of Student: _____ Date: _____

Emergency Contact: _____ (____) _____

Medical Insurance Information

Indicate the status of your personal health insurance coverage. If covered, the information indicated below must be provided for all applicable policies.

_____ I am not covered by a health/accident insurance policy.

_____ I am covered by my own health/accident insurance policy.

_____ I am covered by my parent's health/accident insurance policy.

Health Insurance Company Name, Address & Phone:

Group #: _____ Physician _____

ID# _____

As the Parent or Guardian I fully take responsibility for my child to participant in the Maryland Razorbacks Youth Football and Cheer Program.

SIGNATURE OF PARENT OR GUARDIAN:



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PART II – MEDICAL EVALUATION

Name _____ DOB _____ Age _____

NOTE TO LICENSED HEALTH CARE PRACTITIONERS : The person being evaluated will be participating in youth sports. Please review the health history with the participant for any interim changes. **Explain any “abnormal” evaluations.**

PHYSICAL EXAMINATION To be filled out by a licensed health-care practitioner

Height _____ Weight _____ BP _____ / _____ Pulse _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

Approved for activities (Cheerleading, contact football, flag football) **Yes No** (list below)

LIMITATIONS:

Activity restrictions _____

Diet restrictions _____

Signature _____ M.D./D.O. Date _____

Name (print) _____ Telephone _____

Address _____

City, State, Zip _____

Physician’s Office Stamp

Date _____

Record of findings, diagnoses, treatment, instructions or dispositions.

