Vestal Youth Football and Cheer Medical Form

Parental Consent for Physical Examination, Emergency Medical Evaluation, Care and Transportation

PARENT COMPLETE ALL SECTIONS

PERSONAL/MEDICAL INFORMATION

☐ Flag
☐ Cheer
Division: ☐ Lower ☐ Middle ☐ Upper Team: _____
☐ M ☐ F Age: _____
Home Address: _____ Height: _____ Weight: _____
Immunizations up to date: ☐ Yes ☐ No
Primary Care Physician/Pediatrician: _____
Medications: ☐ None _____
Date of Last Tetnus: _____
Ortho Preference: _____

Allergies to Medication: ☐ None ☐ Detail medication and reaction: _____
Environmental Allergies: ☐ None ☐ Bees ☐ Shellfish ☐ Nuts ☐ Latex ☐ Other: _____
Past Medical/Surgical History: _____
☐ Mono ☐ Splenomegaly ☐ Braces/Caps ☐ Diabetes ☐ Headaches ☐ Heart Problems/Murmur ☐ Seizures
☐ High Blood Pressure ☐ Loss of Conciousness/Concussion ☐ Behavioral/Psych ☐ Wears Glasses/Contacts
☐ Missing one testicle ☐ Kidney problem/missing kidney ☐ Light headedness/dizziness ☐ Hepatitis ☐ Hearing impairment
☐ Any illness requiring Emergency Room, overnight hospitilization or surgery. Details: _____

☐ All fractures, sprains, strains: _____
☐ Blindness in one eye, detached retina/cataract, vision problems, wears glasses

EMERGENCY CONTACT INFORMATION

	Name	Home Phone	Business Phone	Cell Phone
Mom				
Dad				
Emergency Contact				

Hospital preference: ☐ Wilson Regional Medical Center (Area-Level II Trauma Center)
☐ Binghamton General Hospital ☐ Lourdes/Guthrie

I, _____, the parent and/or legal gaurdian of _____ hereby authorize the Vestal Youth Football League, its medical staff and its emergency medical services staff to examine, evaluate, treat and/or transport my child (to a local hopistal by ambulance, if necessary). I also authorize the VYFL staff to share protected medical information about my child concerning VYFL participation.

I further authorize UHS Hospitals and Lourdes/Guthrie physicians and staff to provide emergency medical care and stabilizing treatment to my child in the event I cannot immediately be reached to provide consent. This includes consent for ambulance transport.

Date _____ Parent/Legal Gaurdian signature _____

Date _____ Witness _____

PARENT COMPLETE LIST OF CURRENT MEDICATION HERE

MEDICATIONS:

NAME OF MEDICATION	DOSE	ROUTE	FREQUENCY	REASON
☐ Epipen				
☐ Inhaler				

Vestal Youth Football/Cheer/Flag is managed by parent/family/comuunity volunteers. The following questions are required and pertain to how you and your family could support VYFL operations:

Parents or family members that attend games or practices are asked to identify themselves here as to how you could help VYFL or Cheer

1. Parent Name _____ Email: _____ Cell: _____
2. Parent Name _____ Email: _____ Cell: _____
3. Family Member _____ Email: _____ Cell: _____

What experience do you have?
☐ Coaching ☐ Concessions ☐ Board ☐ Finance
☐ Lawyer ☐ Engineer ☐ Police ☐ Other: _____

If you are a licensed or certified healthcare professional please indicate here:

☐ MD/DO ☐ RN ☐ LPN ☐ DPT/PT ☐ ATC ☐ CRNA ☐ LF ☐ CPR/AED/First Aid Certified
☐ Psychologist ☐ MSW/LCSW ☐ Bio Med Tech ☐ D.C. ☐ Resp Therapist ☐ NP ☐ RPAC
☐ EMT ☐ Paramedic Other: _____

All Flag, Cheer, and Contact Football players are required annually to have a pre-participation medical history and physical examination by your medical provider and retain that record prior to the start of each season. VYFL does NOT require a copy of this phtsical exam.

Athlete's Name: _____

Confidential - Protected Health Information
Return to Coach ASAP

NEW YORK STATE DEPARTMENT OF HEALTH
Emergency Medical Services

Part 18 Public Function Medical Incident Log

Sponsor/Operator	Event Name	EMT Supervisor	Page of

Incident Number	Date	Time	Patient Name & PCR Serial Number	Chief Complaint Injury/Illness	Treatment	Disposition Note: Any Amb. Transport	Comments

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