

MEDICAL WAIVER AND PARENT PERMISSION FOR PARTICIPATION IN WARRIORS FOOTBALL LEAGUE

PLEASE PRINT

PARTICIPANT NAME _____

AGE _____ DOB _____ GRADE _____ SCHOOL _____

ACTIVITY (CHECK ONE) – FLAG FOOTBALL _____ TACKLE FOOTBALL _____ SPRING CLINIC _____

PARENT NAME _____ CONTACT # _____

ADDRESS _____ APT # _____ ZIP CODE _____

EMAIL ADDRESS _____

PHYSICIAN NAME (LAST MEDICAL EXAM) _____

PHYSICIAN PHONE NUMBER _____ DATE OF LAST MEDICAL EXAM _____

ANSWER ALL QUESTIONS - CHECK YES OR NO - IF YES EXPLAIN

- HAS THE PARTICIPANT HAD COVID-19 SYMPTOMS IN THE PAST 10 DAYS YES ____ NO ____
- HAS THE PARTICIPANT BEEN IN CLOSE CONTACT WITH A CONFIRMED OR SUSPECTED COVID-19 CASE IN THE PAST 14 DAYS? YES ____ NO ____
- SERIOUS DISEASE, INJURY, LOSS OR ABSENCE OF AN ORGAN? LOSS OF VISION YES ____ NO ____
- ASTHMA OR REACTIVE AIRWAY DISEASE? YES ____ NO ____
- SEVERE REACTION TO FOOD OR MEDICINE YES ____ NO ____
- HISTORY OF DIZZINESS, FAINTING, HEAT INTOLERANCE OR SEIZURE DISORDER? YES ____ NO ____
- HISTORY OF HEART PROBLEMS, MURMURS, EXTRA BEATS OR HIGH BLOOD PRESSURE? YES ____ NO ____
- HISTORY OF CONCUSSIONS OR HEAD INJURIES YES ____ NO ____
IF YES, WHEN DID THIS OCCUR? _____
- HISTORY OF DIABETES? YES ____ NO ____
- ANY DISABILITIES OR CHRONIC ILLNESSES? YES ____ NO ____
- HAS THE PARTICIPANT BEEN REFUSED PARTICIPATION IN A SPORT DUE TO A MEDICAL PROBLEM? YES ____ NO ____
- DOES THE PARTICIPANT NEED TO CARRY AN INHALER OR OTHER MEDICATION DURING ACTIVITY? YES ____ NO ____

DOES THE PARTICIPANT WEAR BRACES ____ GLASSES ____ CONTACTS ____
REMOVABLE DENTAL PIECE ____ ? YES ____ NO ____

AS THE PARENT OR GUARDIAN OF **I TAKE FULL RESPONSIBILITY**
FOR THE USE OF ANY OF THE ABOVE DURING PARTICIPATE IN THE ABOVE- NAMED PROGRAMS

- CURRENT MEDICATIONS _____

**MY SON/DAUGHTER HAS MY PERMISSION TO PARTICIPATE IN THE ABOVE-NAMED PROGRAM
HOSTED BY THE WARRIORS FOOTBALL LEAGUE, INC**

PARENT/GUARDIAN SIGNATURE _____ DATE _____