

Stoughton Youth Flag Football League (SYFFL) **Medical Release Form**

Note: to be carried by any regular season or tournament team Manager/Coach/Team Parent or League Official along with team roster or eligibility affidavit

Players Name: _____

Date of Birth: _____

Parent or Guardian Authorization:

In case of emergency, if a family physician can not be contacted, I hereby authorize my child to be treated by certified emergency and medical personnel (i.e. EMS, First Responder, and ER Physician).

Name	Phone #	Relationship to Player
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The purpose of the following information is to ensure that medical personnel have as many details available to of any medical problems which may alter or interfere with proper treatment.

Please list any medical problems below in the corresponding section:

Allergies/Reactions:

To medicine, food or environmental

Allergies/ Reactions to:	Type of reaction:	Medication taken for allergy
1.		
2.		
3.		
4.		

Medications:

Medication:	Dosage	Taken For
1.		
2.		
3.		
4.		
5.		

Medical Problems:

(I.e. Asthma, Diabetes, seizure disorder, etc...)

List of Medical Problems:		
1.	2.	3.
4.	5.	6.
7.	8.	9.

Date of last Tetanus Toxoid Booster _____ / _____ / _____
Date

I authorize my child to take a breathing treatment as instructed by his physician if I am not present at an event. _____ / _____ / _____

Name of Parent/Guardian Signature Date

Mr./Mrs./Ms. _____ / _____ / _____
Authorized Parent/Guardian Signature Date