MEDICAL FORM

Student's Name: _____

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 any such injury may lead to permanent disability or death. In the event of routine or emergency health examinations diagnostic procedures, treatment of illness, and/or injuries, I hereby grant permission to the National Football League Foundation ("Foundation") and/or its medical staff, physicians associated with other community or Foundation facilities, as needed, to treat the individual named above.

Signature of Parent: _____ Date: _____

Signature of Student: _____ Date: _____

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: _____

_____

Group #: _____ Policy #:_____

Physician Consent

Height: _____ Weight: _____ Blood Pressure: _____

Allergies: _____

Medication individual is taking: _____

Previous Medical Conditions: _____

_____

Previous Orthopedic Conditions: _____

_____ Student cleared for all full contact physical activities (*i.e.*, full contact football)

_____ Student restricted from physical activities, reason and/or conditions for clearance (if any)

Conditions for clearance (if any): _____

_____

Signature of Doctor: _____ Date: _____

(Doctor's stamp of approval also required)