ST. CHARLES FOOTBALL LEAGUE

Medical Approval Form

Player's Name:_____

Address:_____

Date of Birth:_____ Coach:_____

The above named player is known to me, is physically fit to play full-contact football and has no impairments that would prohibit full participation in contact football activities.

Physician
Signature:_____ Date:_____

Physician Address (Required):_____

_____

Physician Phone (Required):_____

Print Physician Name:_____

Physician's Office Stamp: