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'S SIGNITURE: _____ DATE: _____

PHYSICIAN'S ADDRESS (REQUIRED): _____

_____

PHYSICIAN'S PHONE (REQUIRED): _____

PRINT PHYSICIAN'S NAME: _____

PHYSICIAN'S OFFICE STAMP: