COLUMBIA RAVENS FOOTBALL, INC.
MEDICAL EVALUATION FOR PARTICIPATION

THIS FORM MUST BE COMPLETED, DATED AND
SIGNED BY A PHYSICIAN ON OR AFTER JULY 25, 2014

Players Name: _____ Birthday: _____

Age as of 8/1/15: _____ Weight: _____

I have personally examined the participant, and I find that he/she is physically able to compete in supervised Contact Football.

_____MD _____
Physician Signature Date Address

_____MD _____
Physician's Name (Typed or Printed) Date of Examination

_____
Physician's Phone Number

EMERGENCY MEDICAL TREATMENT AUTHORIZATION
COLUMBIA RAVENS FOOTBALL, INC.

I, _____, do hereby authorize **EMERGENCY MEDICAL TREATMENT** to be
(Parent or Guardian)
given by any recognized medical facility administering **Emergency Treatment** to _____,
(Football Player)
in the event that I am unable to be reached at the time of the injury or accident.

Parent or Guardian_____

Address_____ Phone #_____

Insurance Carrier_____

Insurance Carrier Address_____

Policy or Group No._____

Employer_____ Employer Address_____

Work Phone_____

BRIEF MEDICAL HISTORY

Allergies_____ Medications_____

Last Tetanus shot_____ Family Physician_____

Other INFO or Health Concers_____

Signature of Parent or Guardian_____ Date_____