



KENNEBUNK –KENNEBUNKPORT YOUTH  
FOOTBALL & CHEERING ASSOCIATION

P.O. BOX 83, KENNEBUNK, ME 04043  
WWW.KENNEBUNKYOUTHFOOTBALL.ORG

Medical Health & Release Form

Participant Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Participant's Health Provider (to be completed by parent or guardian)

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Other Medical Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Does Participant have any allergies and/or asthma: YES: \_\_\_\_\_ NO: \_\_\_\_\_

Other conditions: \_\_\_\_\_

By signing below I am stating:

1) To the best of my/our knowledge the information above is correct, and I/we understand that misrepresentation of any of the information contained will result in the participant being denied the opportunity to participate in Kennebunk/Kennebunkport Youth Football & Cheering Association program.

2) I/We grant permission for my son/daughter to be treated for any medical conditions that may arise during practice or games.

3) I/We grant permission for any coach or volunteers transport my son/daughter to receive appropriate medical care should the need arise.

Parent's (Guardian) signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Doctor's Physical Examination Clearance (to be completed by participant's physician):**

\_\_\_\_\_ was been examined in my office on \_\_\_\_\_

(Participant Name)

(Date of exam)

And may participate in the Kennebunk/Kennebunkport youth Football & Cheering program  WITH/ WITHOUT limitations. Any limitations will be noted below.

Limitations (if applicable) \_\_\_\_\_

Doctor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

DR Signature: \_\_\_\_\_ Date: \_\_\_\_\_