



TROY YOUTH FOOTBALL ASSOCIATION
"TROY COWBOYS"
 2009 REGISTRATION FORM



PARTICIPANT INFORMATION

NAME _____

ADDRESS _____

CITY & ZIP _____

PHONE # _____

BIRTHDATE _____

AGE ON NOVEMBER 1, 2009 _____

GRADE DURING SEASON _____

WEIGHT _____ SQUAD _____

SCHOOL _____

HAVE YOU EVER PLAYED YOUTH FOOTBALL FOR
 A CITY OTHER THAN WHO YOU ARE NOW REGISTERING FOR? IF YES, PLEASE LIST THE CITIES _____

Y N
 RELEASE NEEDED COPY ATTACHED

PARENT INFORMATION

MOTHER'S NAME _____

EMERGENCY # _____

FATHER'S NAME _____

EMERGENCY # _____

1st E-MAIL ADDRESS _____

2nd E-MAIL ADDRESS _____

DOCTOR'S NAME _____

DOCTOR'S # _____

THIRD PARTY EMERGENCY CONTACT NAME _____

PHONE _____

REQUIRED REGISTRATION PAPERWORK

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> REGISTRATION FORM | <input type="checkbox"/> ATHLETIC CONSENT FORM | <input type="checkbox"/> RELEASE OF LIABILITY FORM | <input type="checkbox"/> MEDICAL TREATMENT FORM |
| <input type="checkbox"/> BIRTH CERTIFICATE | <input type="checkbox"/> CURRENT PICTURE | <input type="checkbox"/> FEE
(Tackle-\$150/Flag-\$150) | <input type="checkbox"/> PHYSICAL (Dated after 4/15/2009) |



TROY YOUTH FOOTBALL ASSOCIATION

"TROY COWBOYS"

2009 PHYSICAL EXAMINATION FORM



TO BE COMPLETED BY PARENT OR GUARDIAN
A CURRENT YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE CURRENT SCHOOL YEAR

NAME		GRADE	AGE	WEIGHT
ADDRESS (STREET, CITY, ZIP)				
FATHER'S NAME	FATHER'S WORK #	MOTHER'S NAME	MOTHER'S WORK #	
DOCTORS NAME	DOCTORS PHONE #		EMERGENCY #	

INSURANCE STATEMENT

OUR SON/DAUGHTER WILL COMPLY WITH THE SPECIFIC INSURANCE REGULATIONS OF THE O.M.Y.F.A.

FAMILY INSURANCE CO. _____

CONTRACT # _____

ANY MEDICAL CONDITIONS _____

ALLERGIES _____

MEDICAL HISTORY

HISTORY	YES	NO	HISTORY	YES	NO	HISTORY	YES	NO
HAVE YOU EVER HAD:			HAVE YOU EVER HAD:			DO YOU NOW HAVE:		
FAINTING			JAUNDICE			PAINFUL JOINTS		
DIPHTHERIA			SICKLE-CELL ANEMIA			BACKACHES		
SCARLET FEVER			BLEEDING DISORDER			POUNDING OF HEART		
RHEUMATISM			CONCUSSION			SHORTNESS OF BREATH		
RUPTURE			SPRAIN OR FRACTURE			FREQUENT URINATION		
RHEUMATIC FEVER			SURGERIES			COUGH		
POLIOMYELITIS						NOSEBLEEDS		
PNEUMONIA			DO YOU NOW HAVE:			FREQUENT SORE THROATS		
ASTHMA			BLURRED VISION			STOMACH PAINS		
DIABETES			HEADACHES			CHRONIC FATIGUE		
HEART DISEASE			FAINTING					
KIDNEY DISEASE			CONVULSIONS					
TUBERCULOSIS			BLACKOUTS					

PHYSICAL EXAMINATION

SYSTEM	NORMAN	ABN.	SYSTEM	NORMAN	ABN.
VISION			HEART		
BLOOD PRESSURE			ABDOMEN		
PULSE RATE			HERNIA		
ORTHOPEDIC			GENITALIA/TESTICULAR EXAM		
CHEST			NEUROLOGIC		
LUNGS			MUSCULAR		

MUST BE COMPLETED BY THE EXAMINING MD, DO, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER
(CATEGORIES MAY BE ADDED OR DELETED; CHECK APPROPRIATE COLUMN)

RECOMMENDATIONS: _____

I CERTIFY THAT I HAVE EXAMINED THE ABOVE PARTICIPANT AND RECOMMEND HIM/HER AS BEING ABLE TO COMPETE IN SUPERVISED ATHLETIC ACTIVITIES NOT CROSSED OUT BELOW.

BASEBALL - BASKETBALL - CHEERLEADING - CROSS COUNTRY - FOOTBALL - GOLF - GYMNASTICS
ICE HOCKEY - SKIING - SOCCER - SOFTBALL - SWIMMING - TENNIS - TRACK - VOLLEYBALL - WRESTLING

X _____ EXAMINER SIGNATURE	_____
X _____ EXAMINER PRINTED NAME	_____
X _____ PARENT/GUARDIAN SIGNATURE	_____
	DATE SIGNED
	DATE SIGNED
	DATE SIGNED
	TELEPHONE #
	EMERGENCY #