

Player Information Sheet
OHIO STATE YOUTH FOOTBALL LEAGUE

PLEASE PRINT

www.osyfl.com

Player's Name:		Preferred Name:	
Parent's Names:		Home Phone:	
Email:	Mother Cell:	Father Cell:	
The best way to reach me is:			
I/We, the parent(s) of the above named candidate, authorize OHIO STATE YOUTH FOOTBALL LEAGUE, to publish pictures of my/our child on the local website. Individual pictures or names identifying pictures will not be used. _____ Yes _____ No			
I/We, the parent(s) of the above named participant of the OHIO STATE YOUTH FOOTBALL LEAGUE, do hereby give my/our approval to participate in any and all of the OHIO STATE YOUTH FOOTBALL LEAGUE Sports activities, including transportation to and from the activities. _____ Yes _____ N/A			
I/We, the parent(s) of the above named candidate, know that participation in the OHIO STATE YOUTH FOOTBALL LEAGUE Sports may result in serious injuries, and protective equipment does not prevent all injuries to players. I/we do hereby waive, release, absolve, indemnify, and agree to hold harmless the OHIO STATE YOUTH FOOTBALL LEAGUE, the organizers, sponsors, participants, and persons transporting my/our child to and from activities for any claim arising out of any injury to my/our child, whether the result of negligence or for any other cause, except to the extent and in the amount covered by accident or liability insurance. _____ Yes _____ N/A			

Parent or Guardian Authorization: In case of an emergency, if I, or the family physician, cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, ER Physician).		
Family Physician:		Phone:
Address:		City:
Hospital Preference:		
In Case of Emergency, contact: (someone other than parents)		
Name:	Work Phone:	Relationship to Player:
Home Phone:	Cell Phone:	Pager:
Name:	Work Phone:	Relationship to Player:
Home Phone:	Cell Phone:	Pager:
Please list any allergies/medical problems, including those requiring maintenance medications (i.e. diabetic, asthma, seizure disorder). Include medical diagnosis, medication, dosage, and frequency of dosage.		

_____	_____
Parent/ Guardian Signature	Date