

2026 NORTH BAY YOUTH FOOTBALL - PLAY ALLOTMENT ROSTER

TEAM NAME : _____ NUMBER OF PLAYERS _____

AGE/WT/DIVISION : _____ DATE _____

OPPOSING TEAMS WEIGHMASTER SIGNATURE _____

DIRECTIONS

This form is to be completed in two copies. One copy is for use by the **PLAY ALLOTMENT RULE MONITORS**, and is the official field roster for the game. The second roster is to be given to the PA announcer prior game time.

ALL PLAYERS ARE REQUIRED TO PLAY 6 PLAYS DURING THE GAME

PAR MONITORS: Each team must provide two PAR monitors. These monitors will be paired to form two monitoring teams, with one monitor from each team assigned together. One monitoring team will be assigned to each sideline. On the home team's sideline, the visiting team's monitor will hold the home team's PAR form on a clipboard. On the visitor's sideline, the home team's monitor will hold the visitor's PAR form on a clipboard.

Five minutes prior to the end of each half, the respective monitor will notify its head coach of how many players have not completed their mandatory number of plays and what their jersey numbers are. Final notification shall be given two minutes prior to the end of the game, if they still have not completed PAR. If any player fails to play the minimum number of plays, both of the Presidents are to be notified and the jersey number(s) written down in the space provided below.

PLAYER(S) JERSEY NUMBER _____ / _____ / _____ / _____

IF A PLAYER OR COACH IS EJECTED FROM THE GAME, THEIR NAME MUST BE LISTED BELOW. FOR PLAYERS, INCLUDE THE JERSEY NUMBER.

At the completion of the game, this form is to be signed by both teams PAR MONITORS. Then the form will then be given to the opposing association's president. The president will then sign and date the form in the space provided below and keep on file for possible future needs.

BY THE SIGNATURES BELOW WE CERTIFY THAT THE INFORMATION ABOVE AND ON THE REVERSE SIDE OF THIS FORM IS CORRECT.

Home Teams _____ Visiting Teams _____
PAR MONITOR _____ PAR MONITOR _____

VERIFICATION OF QUALIFIED MEDICAL PERSON ON THE FIELD

Name of medical person: _____ Qualification: is. EMT 1, MD, etc: _____

Qualification number: _____ SIGNATURE _____ DATE _____

BY THE SIGNATURES BELOW, I CERTIFY THAT THE INFORMATION ABOVE AND ON THE REVERSE SIDE OF THIS FORM IS CORRECT.

Opposite
Association President _____ Date _____

