Medical Clearance Form

ASSOCIATION NAME - _____

Medical Clearance Form - Must be dated after January 1st of the Current Season

I, hereby my signature below, do certify that I am licensed by the state and am qualified in determining that: (Childs Name:)_____ is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating in Youth Flag Football, Full Contact Tackle Football, Cheer, Dance, Step or any other athletic activities. I am therefore clearing this individual for Full Contact / Athletic Participation.

I am therefore clearing this individual for athletic participation.

Please Print - or - Use Office Stamp Here:

Signature: _____	Print Name Clearly: _____
(Must be dated after January 1st, of the Current Season)	*Office Address:*
Date: / / ____	_____

PLEASE NOTE: If this Medical Clearance is voided by injury, accident, or illness, Concussion or Suspected Concussion it will be the responsibility of the Parent/Legal Guardian to notify the participants Coach and League Officials. It will also be the responsibility of the Parent / Legal Guardian to obtain WRITTEN permission from his/her physician to resume participation. A "Doctors Resume Participation Medical Clearance Form" is available from the league or you may have the doctor supply his/her own WRITTEN Clearance as long as it is on the doctor's official stationary and includes the following statement: "(Participants Name) is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating in Youth Flag Football, Full Contact Tackle Football, Cheer, Dance, Step or any other athletic activities. I am therefore clearing this individual for Full Contact / Athletic Participation.

This statement must be supplied by the physician attending to the injury, accident, or illness. This form can be modified or substituted ONLY to comply with local and/or state laws or due to medical practitioner regulations.

MEDICAL HISTORY – To be completed by participant/parent

Athlete's Directions: Please review all questions with your parent or guardian and answer them to the best of your knowledge.

1.	Has anyone in the athlete's family (Parent, Grandparent, sibling, aunt, uncle), died suddenly before age 50?	Yes	No	Don't Know	2. Has the athlete ever suffered a heat-related illness (heat stroke)?	Yes	No	Don't Know
3.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	Yes	No	Don't Know	4. Does the athlete have a chronic illness or see a doctor regularly for any particularly problem?	Yes	No	Don't Know
5.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?	Yes	No	Don't Know	6. Does the athlete take any medicine?	Yes	No	Don't Know
7.	Has the athlete ever had a bone broken, had to wear a cast, or had an injury to any joint?	Yes	No	Don't Know	8. Is the athlete allergic to any medication or bee stings?	Yes	No	Don't Know
9.	Does the athlete have a history of a concussion (being knocked out)?	Yes	No	Don't Know	10. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?	Yes	No	Don't Know

*Please explain all "Yes" answers —**use the back if necessary.**

MEDICAL EXAMINATION – To be completed by Physician

Height: _____ Weight: _____ Blood Pressure: _____

	Normal	Abnormal	Description of Abnormality
Musculoskeletal Exam:			
			Knee
			Ankle
			Shoulder
			Other Joints
			Alignment Problems
			Scoliosis
			Estimate of Flexibility
Eyes:			
Genitalia (males):			
Cardiovascular Exam:			Other Exam (if indicated by history):

PARENT SIGNATURE: _____ DATE: _____