



AMERICAN YOUTH FOOTBALL

Medical Clearance Form



ASSOCIATION NAME - CentralFloridaYouthFootball

Medical Clearance Form - Must be dated after January 1, 20__

I, hereby my signature below, do certify that I am licensed by the state and am qualified in determining that: (Childs Name: _____) [Date of Birth: _____] is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating in youth flag football, tackle football, cheer, dance, step or athletic activities. I am therefore clearing this individual for athletic participation.

Physician Signature: _____ Date: ____/____/____ (Must be dated after January 1st, of the Current Season) Please Print - or - Use Office Stamp Here: Print Name Clearly: _____ Office Address: _____

PLEASE NOTE: If this Medical Clearance is voided by injury, accident, or illness, 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, tackle football, cheer, dance, step or athletic activities. I am therefore clearing this individual for 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.

Table with 10 rows and 9 columns. Questions include: 1. Has anyone in the athlete's family (Parent, Grandparent, sibling, aunt, uncle), died suddenly before age 50? 2. Has the athlete ever suffered a heat-related illness (heat stroke)? 3. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? 4. Does the athlete have a chronic illness or see a doctor regularly for any particularly problem? 5. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? 6. Does the athlete take any medicine? 7. Has the athlete ever had a bone broken, had to wear a cast, or had an injury to any joint? 8. Is the athlete allergic to any medication or bee stings? 9. Does the athlete have a history of a concussion (being knocked out)? 10. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?

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

MEDICAL EXAMINATION – To be completed by Physician

Height: _____ Weight: _____ Blood Pressure: _____

Table with 4 columns: Exam Type, Normal, Abnormal, Description of Abnormality. Rows include Musculoskeletal Exam (Knee, Ankle, Shoulder, Other Joints, Alignment Problems, Scoliosis, Estimate of Flexibility), Eyes, Genitalia (males), and Cardiovascular Exam (Other Exam (if indicated by history)).