

**William Foley Football League
2023 Medical Clearance Form**

Note: This is a 2 section form. Section 1 **MUST** be completed by Parent/Guardian, section 2 **MUST** be completed by a medical professional **ONLY!**

Section 1: FOR PARENT/GUARDIAN COMPLETION ONLY

Legal name of participant (must match birth certificate) _____
Last _____ First _____ Middle _____
Street Address _____
City _____ State _____ Zip _____
Telephone No. _____ Date of Birth _____ Male _____ Female _____
Primary Medical Insurance Co. _____ Policy # _____
Membership _____ Name of Primary Insured _____
Sport (check one) _____ Cheer _____ Football _____

PARTICIPANT MEDICAL HISTORY

- | | |
|---|--------------------|
| 1. Are there any injuries requiring medical attention? | Yes _____ No _____ |
| 2. Are there any past surgeries or schedule surgeries? | Yes _____ No _____ |
| 3. Is the participant currently under the care of a medical practitioner? | Yes _____ No _____ |
| 4. Is the participant currently taking any medications? | Yes _____ No _____ |
| 5. Does the participant have any allergies (penicillin, bee stings, etc.) | Yes _____ No _____ |
| 6. Does the participant have asthma/require the use of an inhaler? | Yes _____ No _____ |
| 7. Is the participant diabetic/require medication for diabetes? | Yes _____ No _____ |
| 8. Does the participant currently require medication? | Yes _____ No _____ |
| 9. Does/has the participant have/had seizures? | Yes _____ No _____ |
| 10. Does the participant wear glasses or contact lenses? | Yes _____ No _____ |
| 11. Does the participant wear a brace or other medical support device? | Yes _____ No _____ |
| 12. Does the participant have any other physical limitations or medical conditions? | Yes _____ No _____ |

If you answered yes to any of the above questions, please provide the question number and an explanation below. If needed write on back also.

I hereby certify that this information is accurate to the best of my knowledge. I understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that it is my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signature of Parent/Legal Guardian _____

Print Name _____

Relationship to Participant _____ Date _____

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Section 2: THIS SECTION MUST BE COMPLETED ONLY BY A MEDICAL PROFESSIONAL

Name of Participant _____
(Please check the following if healthy or note otherwise)

____ Height	____ Weight	____ Eyes
____ Ears	____ Mouth	____ Nose & Throat
____ Respiratory	____ Cardiovascular	____ Neurological
____ Muskoskelatal	____ Dermatological	____ Blood Pressure

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be involved in participation in William Foley Football & Cheerleading. I hereby swear and attest that this individual is physically fit and have found no medical reason which would prevent this individual from safely participating in William Foley activities for the 2017 season. I am clearing this individual for athletic participation without limitation.

Please place medical professional stamp here or fill out the following COMPLETELY:

Signed _____ Date _____

Print Name _____

Please indicate medical profession (M.D. D.O. R.N., etc.) _____

Complete this section or medical professional's stamp may be placed below.

Address _____

City _____ State _____ Zip _____

Telephone _____ Fax Number _____

Section 2 MUST be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.)