AMERICAN YOUTH FOOTBALL
Medical Clearance Form

ASSOCIATION NAME - _____

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

I, as evidenced by my name and signature below, do certify that I am a State Licensed Medical Examiner in the state of_____and am qualified in determining that:

(Childs Name:)_____is physically fit and I have found no medical or observable conditions which would contra-indicate his/her from participating in youth flag football, tackle football, cheer, dance, step or athletic activities.

I am therefore clearing this individual for athletic participation.

Please Print - or - Use Office Stamp Here:

Signature: _____	Print Name Clearly: _____
Date: / / *(Must be dated after January 1st, of the Current Season)* _____	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 State Licensed Medical Examiner 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.

NOTE: This form as with any and all forms used by your Association should be reviewed by your local counsel for compliance with any state or local statutes. This form should be kept on file for a minimum of 7 years, longer in the event of an injury. Please confer with your local attorney for advice as to the appropriate maintenance and storage term for this and all such forms.

DESERT VALLEY YOUTH FOOTBALL AND CHEER CONFERENCE

PHYSICAL EXAMINATION FORM

ORIGINAL AND TWO COPIES ARE REQUIRED TO COMPLETE YOUR REGISTRATION

ASSOCIATION NAME: _____ **DIVISION:** _____

Athlete's Name: _____ **Birth date:** _____
LAST FIRST MI

Athlete's Address: _____ **Family Dr.:** _____ **Dr.'s Phone:** _____

The above-named athlete has my permission to participate in the Desert Valley Youth Football and Cheer Conference, activities and has permission to travel with a representative of the Desert Valley Youth Football and Cheer Conference, and the local Association on any trips. In case of injury a Inland Empire Youth Football and Cheer Conference, representative is authorized to have him/her treated and/or hospitalized by any one of the doctors cooperating with the Desert Valley Youth Football and Cheer Conference, and I will not hold the Desert Valley Youth Football and Cheer Conference, the Shadow Hills Youth Football & Cheer Chapter or its representatives responsible for payment as the result of any accident or injury.

Medical History (to be completed by parent/guardian)

R or L Handed: _____ **Allergies to Medication:** _____

Has athlete had the following:	Circle one:		Explain "Yes" Answers
1. Injuries to head, neck, bones or joints	Yes	No	
2. Any other injuries requiring medical attention	Yes	No	
3. Seizures, blackouts or any episode of unconsciousness	Yes	No	
4. Heart trouble, heart murmur, high blood pressure	Yes	No	
5. Hospitalization or operations in the past	Yes	No	
6. Any Serious Infectious Disease	Yes	No	
7. Stomach, intestinal, or urinary tract problems	Yes	No	
8. Is athlete under care of a doctor now	Yes	No	
9. Is athlete taking any medication on a regular basis	Yes	No	
10. Any dental problems	Yes	No	
11. Does the athlete have Asthma	Yes	No	
12. Any allergies *(please list **ALL** food or medicine)*	Yes	No	

Parent or Legal Guardian Signature: _____ **Date:** _____

Physical Examination (to be completed by physician)

Date of physical: _____

Height: _____ **Weight:** _____

Blood Pressure: _____ **Pulse:** _____

☐ Heart ☐ Ears ☐ Nose ☐ Teeth ☐ Abdomen ☐ Extremities

Remarks: _____

Dr. Office Seal Or Stamp Here. If "NONE" Then Attach the Doctor's Business Card Here (Required).

☐ **While this examination does not constitute a complete Medical Examination, it does on this date and based on my observation, meet the requirement for participation in this youth football program.**

☐ **Individual examined by me on this date is considered NOT physically qualified to participate in this youth football program for the following reasons:** _____

_____

Physician's Signature: _____ **M.D. Date:** _____ **Phone:** _____