EMC Football/Cheerleading

Medical Release

Participant Name DOB

Please Check: Male____ Female ____

Name of Primary Care Physician

Insurance Group Number

PARTICIPANT MEDICAL HISTORY *(please circle)*

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

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 I may not be cleared for participation at such time. I hereby acknowledge that it is my responsibility to inform my coach or organization official in writing if there is any change in my medical condition. I also understand that it's my responsibility to obtain written permission from my physician on official medical conditions in order to seek permission to participate.

Parent/Guardian Signature Date

EMC Football/Cheerleading

Physical Release

THIS SECTION MUST BE COMPLETED AND STAMPED ONLY BY A LICENSED MEDICAL PROFESSIONAL

Participant Name DOB

Height _____ Weight _____ Eyes _____ Ears _____

Mouth _____ Nose & Throat _____ Respiratory _____

Cardiovascular _____ Blood Pressure _____ Neurological _____

I hereby certify that I am a licensed state examiner and have examined the above named individual. I understand the above will be participating in New Life Football League. This individual is physically fit and I have found no medical reason which would prevent this individual from safely participating

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Printed Name of Medical Professional

Signature of Medical Professional Date

Professional Stamp