William Foley Football League
2024 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 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.)