MEDICAL FORM

CLARENCE LITTLE LEAGUE FOOTBALL ASSOCIATION

P.O. BOX 432, CLARENCE CENTER, NY 14032

PLEASE PRINT CLEARLY

CHILD'S NAME ______________________

ADDRESS ______________________ PHONE __________

____

DATE OF BIRTH __________ AGE __________

PARENT OR GUARDIAN ______________________ (as of August 1st)

IN CASE OF EMERGENCY (OTHER THAN YOURSELF) ______________________

RELATIONSHIP ______________________ PHONE __________

FAMILY MD ______________________ PHONE __________

MD ADDRESS ______________________

DOES YOUR HEALTH INSURANCE HAVE ANY SPECIAL INSTRUCTIONS IN CASE OF AN EMERGENCY THAT WE SHOULD BE AWARE OF IF YOU ARE NOT IMMEDIATELY AVAILABLE?

The medical services are provided without gratuity. Therefore, we will not assume any liability due to injury on the field. If you have any medical training and would like to volunteer your time, please let us know. All are welcome.

I feel that my child ______________________ is physically fit to participate in calisthenics and contact scrimmages, I shall not hold the CLLFA, cheerleading, or organizers responsible for any problems arising because of a previous health problem or injury.

I also understand that before my child will be allowed to participate in actual game play of football, it is a league ruling that he/she must have a physicians physical.

If your child does not have a physicians physical, they will NOT be issued a uniform until after they have their physical. THERE WILL BE NO EXCEPTIONS TO THIS RULE. The child will be expected to attend practice, participate in calisthenics, and to learn all the plays required. Although not able to participate in physical contact, they can learn a lot from just watching and listening.

______________________ __________

SIGNATURE OF PARENT OR GUARDIAN DATE

CHILD'S HISTORY: Does your child have or had the following? Answer Yes or No

BLEEDING TENDENCIES		ALLERGIES		PNEUMONIA	
RHEUMATIC DISEASE		BRONCHITIS		ANEMIA	
SPINAL DISEASE		FRACTURES		SURGERY	
BONE DISEASE		ASTHMA		OTHER	
KNEE PROBLEMS		DIABETES			

Has your child ever been hospitalized?		No		Yes, if yes	explain:
Does he/she take medication routinely?		No		Yes, if yes	explain:
Does he/she have alllergies?		No		Yes, if yes	explain:
Does your child have any physical handicaps?		No		Yes, if yes	explain:
Has he/she ever had a problem with bleeding?		No		Yes, if yes	explain:
Any problems with vision or hearing?		No		Yes, if yes	explain:
Any unusual shortness of breath, palpitations, or cough?		No		Yes, if yes	explain:
Any recent weight changes, change in appetite, or bowel habits?		No		Yes, if yes	explain:
Did he/she participate in this program last year?		No		Yes, if yes	explain:

PLAYER NAME ______________________________

WEIGHT __________ HEIGHT __________ BLOOD PRESSURE __________

PULSE __________ URINE ANALYSIS ______________________
glucose/ketones/blood

PHYSICIAN'S EXAM

HEAD & NECK ______________________________

EYES ______________________________

LUNGS & CHEST ______________________________

HEART ______________________________

ABDOMEN ______________________________

GENITALIA ______________________________

SPINE ______________________________

EXTREMITIES ______________________________

PHYSICIAN'S ADDITIONAL COMMENTS: ______________________________

PHYSICAL EXAM: (circle one) NORMAL ABNORMAL
(Explain below if abnormal)

PHYSICIAN CHECK BELOW:
I have seen the above child within the past 12 months. Based upon my finding at that time:

STATUS OK TO PARTICIPATE __________
NEEDS OK FROM FAMILY PHYSICIAN TO PLAY __________
DEFERRED MEDICALLY FOR PARTICIPATION __________

____
(Physician Name Printed)

______________________________ __________
(Signature of Physician) (Date)