THIS FORM NEEDS TO BE COMPLETED 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:
Musculoskeletal:	Dermatological:	Blood Pressure:

I hereby certify that I am a licensed state examiner and examined the above named individual on: _____(Date of physical) I understand that he/she will be participating in the Derry Demons Football program.

I hereby swear and attest that this individual was physically fit and I found no medical reason that would prevent him/her from safely participating in Demons activities for the 2025 season. I am therefore clearing this individual for athletic participation without limitation.

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

Signed _____ Today's Date_____

Print Name_____Address_____

Telephone _____ **This form must be completed in its entirety by a licensed state examiner (Medical Doctor, Nurse Practitioner, etc.) This may vary by state. Must be dated 2025.**