



# San Gabriel Valley Jr. All-American Football Conference, Inc.

## Physical Exam and Medical Release Form



**FRANCHISE NAME:** \_\_\_\_\_ **DATE OF PHYSICAL EXAM:** \_\_\_\_\_

A medical examination by a qualified Medical Practitioner is required for all participants of SGVJAAFC. **The examination may not occur prior to June 1<sup>st</sup> of the current calendar year and must be completed prior to participation by the participant.** This original form must be submitted to the Franchise and filed with SGVJAAFC at Certification. **(No white-out or crossed out forms will be accepted – A new form is required)**

**SECTION I: TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN (NAME MUST MATCH PARTICIPANT CONTRACT)**

PARTICIPANT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX:  MALE  FEMALE

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIPCODE: \_\_\_\_\_

PARENT CELL PHONE: (\_\_\_\_\_) \_\_\_\_\_ ALTERNATE NUMBER: (\_\_\_\_\_) \_\_\_\_\_

**PARTICIPANTS MEDICAL HISTORY: (to be completed by Parent/Guardian and Physician):**

	YES	NO		YES	NO
1. Does the participant have any current injuries that require medical attention?	<input type="checkbox"/>	<input type="checkbox"/>	7. Is the participant currently taking any prescribed medications?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the player currently under the care of any physician?	<input type="checkbox"/>	<input type="checkbox"/>	8. Does the participant have asthma or require an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does this participant have any allergies (bee stings, penicillin, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	9. Does the participant wear prescribed glasses or have contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the participant diabetic or require medication for diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	10. Does the participant have any known physical limitations or medical conditions?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the participant ever had any seizures?	<input type="checkbox"/>	<input type="checkbox"/>	11. Does the participant wear a brace or other medical support device?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the participant had any surgeries in the past or have any scheduled for the future?	<input type="checkbox"/>	<input type="checkbox"/>	12. Has the participant sustained a concussion or head injury during the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above questions, please provide an explanation for each YES response: \_\_\_\_\_

I hereby certify that this information is accurate to the best of my knowledge. I hereby acknowledge that it is my responsibility to inform Franchise Officials or SGVJAAFC in writing if there is any change to the medial condition of my child. I also understand that it is my responsibility to obtain written clearance from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all injuries, illnesses, or accidents.

Signed: \_\_\_\_\_ Print Name: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION II: THIS SECTION TO BE COMPLETED BY A QUALIFIED MEDICAL PRACTITIONER**

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ BLOOD PRESSURE: \_\_\_\_\_ TEMPERATURE: \_\_\_\_\_  
 EARS: \_\_\_\_\_ EYES: \_\_\_\_\_ NOSE: \_\_\_\_\_ THROAT: \_\_\_\_\_  
 HEART: \_\_\_\_\_ LUNGS: \_\_\_\_\_ SKIN: \_\_\_\_\_ TEETH: \_\_\_\_\_  
 HERNIA \_\_\_\_\_ ABDOMEN: \_\_\_\_\_ EXTREMITIES: \_\_\_\_\_ FEET: \_\_\_\_\_

**ABNORMAL FINDINGS (IF ANY):** \_\_\_\_\_

**PHYSICIAN TO CHECK APPROPRIATE BOX BELOW:**

While this examination **does not** constitute a complete MEDICAL EXAMINATION, it does on this date and based on my observation, **meet the requirements for participation** in the San Gabriel Valley Jr. All-American Football Conference

Individual examined by me on this date is considered **NOT PHYSICALLY QUALIFIED** in this youth football and cheer program for the following reasons: \_\_\_\_\_

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 participating SGVJAA Football or Cheer. I hereby swear and attest that this individual is physically fit and I have found no medical reason which would prevent this individual from safely participating in SGVJAA Football or Cheer activities for the current season.

**\*\*LIVE SIGNATURE & STAMP ARE BOTH REQUIRED FOR PHYSICAL TO BE VALID. LICENSE # MUST BE WRITTEN BELOW ONLY IF NOT ON THE STAMP\*\***

Doctors Name(Printed): \_\_\_\_\_ License #: \_\_\_\_\_

Doctors Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Phone # (if not on stamp): (\_\_\_\_\_) \_\_\_\_\_

Doctor Stamp: