Medical Clearance Form

_____ _____

Last Name First Name Middle Initial Date of Birth

Gender: ___ M ___ F Age: _____ Grade: _____

Parent's Name _____ Phone: _____

_____ Cleared without restriction

_____ Cleared, with recommendations for further evaluation or treatment for: _____

_____

I certify that this athlete is medically qualified to participate in football. I also certify that I am a licensed physician or work directly with a licensed physician.

Parent's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Address: _____

Physician's Phone #: _____