



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 May 1st of the current calendar year and must be completed prior to participation by the participant.** This original form must be submitted to the City Franchise and filed with SGVJAAFC for 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)

ATHLETE'S NAME: _____ DOB: _____ AGE: _____ SEX: _____ FEMALE _____ MALE
ADDRESS: _____ CITY: _____ ZIP CODE: _____
PARENT/GUARDIAN CELL PHONE#:(_____) _____ ALTERNATIVE NUMBER: (_____) _____

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

PARTICIPANT'S MEDICAL HISTORY: (To be completed by Parent/Guardian and Physician): If you answered YES to any of the questions above, please explain each YES response: _____

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

Date: _____

SIGNED: _____ PRINT NAME: _____ RELATIONSHIP TO THE ATHLETE: _____

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

HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	ABNORMAL FINDINGS (IF ANY):
EARS	EYES	NOSE	THROAT	
HEART	LUNGS	SKIN	TEETH	
HERNIA	ABDOMEN	EXTREMITIES	FEET	

PHYSICIAN TO CHECK APPROPRIATE BOX BELOW:

The 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 participate in SGVJAA Football or Cheer. I hereby swear and attest that this individual is physically fit, and I have found no medical reason that would prevent this individual from safely participating in SGVJAA Football or Cheer activities for the current season. While this examination does not constitute a complete MEDICAL EXAMINATION, it meets the requirements for participation in the San Gabriel Valley Jr. All-American Football Conference on this date and based on my observation.

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

Doctor's Name (Print):	License #:	Doctor Stamp:
Doctor's Signature:	Date:	
Office Phone Number (if not on stamp)		