Jr All American of Southern California Conference
Mandatory Medical Release Form

Chapter Name_____**UPLAND**_____ Division_____ Select Division _____

This form must be **dated AFTER March 27, 2020 AND within 4 months prior to first day of practice** and submitted to your Local Chapter. Section I must be completely filled out by the parent or legal guardian. Section II must be completed in its entirety ONLY by a duly qualified Doctor of Medicine, Doctor of Osteopathy, Nurse Practioner, or Physician's Assistant. **A Doctor of Chiropractic and a Registered Nurse are not considered to be qualified to give a physical to a player and a physical will not be accepted from one**

Section 1: FILLED OUT BY PARENT OR LEGAL GUARDIAN (Legal name must match proof of age)

Last: _____First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____Age _____ DOB: _____ Circle M / F

PARTICIPANTS MEDICAL HISTORY

1. **Are there any injuries requiring medical attention? Yes/ No**
2. **Is the participant currently under the care of a doctor? Yes/ No**
3. **Does the participant have any allergies (bee sting, penicillin)? Yes/ No**
4. **Is the participant diabetic/ require medication for Diabetes? Yes/ No**
5. **Does/ has the participant have/had seizures? Yes/ No**
6. **Are there any past surgeries/scheduled surgeries? Yes / No**
7. **Is the participant currently taking any medication? Yes / No**
8. **Does the participant have asthma/require inhaler Yes / No**
9. **Does the participant wear glasses or contact lenses? Yes/ No**
10. **Does the participant have any physical limitation/ medical condition Yes/ No**
11. **Does the participant wear a brace or other medical support Yes/ No**

If you answered YES to any question above, please provide the question number and an explanation below:

_____

_____

I hereby certify that this information is accurate to the best of my knowledge. I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that 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 such injury, illness or accident.

Signed_____ Print Name_____

Relationship to Participant_____ Dated_____

Section II: THIS SECTION IS TO BE COMPLETED ONLY BY A STATE LICENSED MEDICAL PROFESSIONAL

If there are any cross outs, white out, or information written over on this form, this form will be denied and a new physical required

Participant'sName:_____

(Please check the following if healthy or note otherwise): Height _____ Weight _____ (lbs) B/P _____

Ears_____ Mouth _____ Nose_____ Throat_____ Respiratory _____Cardiovascular_____ Neurological _____

Eyes_____/_____Hernia(optional)_____

Notes:_____

_____

_____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 in SCJAAF Football or Cheer Program. 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 SCJAAF Football activities for the 2019 season. I am therefore clearing this individual for athletic participation without limitation.

Signed_____ Print Name_____

Date: _____ ____ Date Physical was actually performed: _____

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Address_____ Mandatory Dr. Stamp Here:

City_____ State_____

Telephone _____