MEDICAL RELEASE FORM

No candidate will be permitted to participate in any Activity until this form has been completed in full.

Organization Name: _____ Age Division & Level : _____

Participant Name: _____

Birthdate: _____ Age: _____

Height: _____ Weight: _____ Gender: ☐ *Male* ☐ *Female*

Medical History:	**Yes**	**No**		**Yes**	**No**
Glasses or Contacts	☐	☐	Seizures	☐	☐
Asthma	☐	☐	Surgery within past year	☐	☐
History of Heart Murmur	☐	☐	Do you cough, wheeze or have difficulty breathing during or after exercise	☐	☐
Repeated bone or Joint injury	☐	☐	Head Injuries within past year	☐	☐
Fractures within past year	☐	☐	Kidneys disease/infections	☐	☐
Dental braces or dentures	☐	☐	Serious illness	☐	☐
Bleeding Tendencies	☐	☐	Sickle Cell Tendency	☐	☐
Allergies	☐	☐	Diabetes	☐	☐

Tetanus Shot Date:_____

Current Medications:_____

_____

Remarks:

Other Medical issues:

_____

_____

_____

Parent/Participant Agreement

1. A participant should be checked with their family doctors to assess their fitness before they begin any sport programs. The parent/guardian is responsible for a player's health and the league assumes no responsibility.
2. Participants should have water bottles with them at practice and games and be reminded to hydrate throughout the day.
3. Participants shall wear adequate protective gear and examine all training and field equipment. Players are to use equipment only for its intended purpose.
4. Suspended and ineligible players cannot participate in any football/cheerleading activity at any E2E games/competitions at any level until he/she presents written clearance from the league he/she has been suspended/expelled.
5. If, in the judgment of a league representative, the named student-athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary
6. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her coach and organization board member of the change immediately
7. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/league athletic director of his/her LEAGUE OR ORGANIZATION.
8. I agree to allow my child's medical history all eligibility forms to be reviewed by the E2E or its Representative(s).

Insurance Information

Name: _____

Company Name: _____

Preferred hospital: _____

Guardian: _____ Phone Number: _____

Relationship to player: _____

Guardian: _____ Phone Number: _____

Relationship to player: _____

(Emergency contact other than guardians)

Emergency Contact: _____ Phone Number: _____
relationship to player: _____

Emergency Contact: _____ Phone Number: _____
relationship to player: _____

By signing below we agree to the statements above and that all information contained here-in is true and accurate to the best of our knowledge.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Physical Examination

Although we E2E would like to have a physical examination completed by a licensed medical professional, we understand that this is not possible for all of our participants. To Opt out of the Physical Examination please check "opt out" below. By doing so, you assume all liability of injury related to existing health issues that could have been discovered during the physical exam.

☐ **OPT OUT**

Parent Signature:_____ **Date:**_____

The following should be completed by a licensed medical professional:

Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Gender:** ☐ *Male* ☐ *Female*

Blood Pressure: _____/_____ **Resting Pulse:** _____

Vision: Right 20/_____ **Left 20/**_____ **Corrected** ☐ **Yes** ☐ **No**

Medical:	**Normal:**	**Abnormal Findings:**
Appearance		
Eyes/Ears/nose/throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitourinary (male only)		
Skin		
Neurological		
Musculoskeletal:	**Normal:**	**Abnormal Findings:**
Neck		
Back		
Shoulder/arm		
Elbow/Forearm		
Wrist/hand/fingers		
Hip/thigh		
knee		
Leg/ankle		
Foot/Toes		
Functional		

Medical Practitioner to School Staff (Please indicate any instructions or recommendations here)

Emergency Medication required on-site: _____ **Inhaler** _____**Epinephrine** _____**Glucagon Other:**_____

Comments:

☐ CLEARED WITHOUT RESTRICTIONS

☐ CLEARD WITH THE FOLLOWING NOTATION:_____

☐ Cleared AFTER documented further evaluation or treatment for:_____

_____

☐ Cleared for LIMITED PARTICIPATION UNTIL DATE:_____Reason:_____

☐ NOT CLEARED FOR PARTICIPATION Reason: _____

By this signature, I attest that I have examined the above student athlete and completed this pre-participation physical.

Physician Signature:_____(*MD, DO,LNP, PA)Date:_____

Examiner's Name and degree (print):_____Phone Number:_____

Address:_____City:_____State:_____Zip:_____

**Only signatures of Doctor of Medicine, Doctor of Osteopathic Medicine, Nurse Practitioner or Physician's Assistant licensed to practice in the United States will be accepted.*