Team Sports Medical Clearance Form

Participant Information

Full Name

Date of Birth

Sport/Team

Gender

Address

Emergency Contact Name & Phone

Medical History

Please list any allergies, chronic illnesses, or medical conditions:

Current Medications (if any):

Physical Restrictions or Limitations:

Physician Examination

Date of Examination

Comments/Findings:

Medical Clearance

Select one

Physician's Signature

Print Name

Physician Name

Date

Parent/Guardian Signature

Print Name

Parent/Guardian Name

Date