FAIRFIELD YOUTH FOOTBALL AND CHEERLEADING

MEDICAL CLEARANCE FORM

MUST BE COMPLETED BY PHYSICIAN BEFORE YOUR CHILD MAY PARTICIPATE IN PRACTICES OR GAMES

Child’s Full Name:			
Address:			
Parent or Legal Guardian:			
Cell/Home Phone:		Work Phone:	
Emergency Contact: (If parents or guardians are not available)			
Cell/Home Phone:		Work Phone:	

Authorization for Medical Care			
I authorize any league and/or team official to act for me in my absence to use his/her best judgment in the event of a medical emergency requiring medical attention. I hereby waive my right to bring any claim against such individual in the exercise of such judgment. I recognize that insurance coverage for injuries received during the 2025 season is the responsibility of the parent or guardian’s insurance policy.			
Parent or Guardian Signature:		**Date:**	

Parent or Guardian Authorization			
Football is an athletic activity that involves body contact between participants. While every precaution is taken to avoid injury, the risk of injury is always present. Additionally, every effort is made to ensure all coaches within our league are well-trained and are permitted to work with children. The above-named player has my permission to play football and to participate in all practice sessions and games for the 2025 season. By signing this form, I waive any and all causes of action that may arise in connection with or incidental to the player’s participation in this sport. I further waive any and all claims against the FFI, CFA, and its officers for any unforeseeable event or for injury that may occur, and recognize that if any of the information contained within this medical clearance form is found to be false, the player will immediately be disqualified from participating in the CFA Football League.			
Parent or Guardian Signature:		**Date:**	

MEDICAL HISTORY

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	YES	NO
Have you had a medical illness or injury since your last sports physical?		
Do you have an ongoing or chronic illness?		
Have you ever been hospitalized overnight?		
Have you ever had surgery?		
Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?		
Have you ever had a rash or hives develop during or after exercise?		
Have you ever passed out during or after exercise?		
Have you ever been dizzy during or after exercise?		
Have you ever had chest pain during or after exercise?		
Do you get tired more quickly than your friends do during exercise?		
Have you ever had racing of your heart or skipped heartbeats?		
Have you had high blood pressure or high cholesterol?		
Have you ever been told you have a heart murmur?		
Has any family member or relative died of heart problems or of sudden death before age 50?		
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?		
Has a physician ever denied or restricted your participation in sports for any heart problems?		
Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?		
Have you ever had a head injury or concussion?		
Have you ever been knocked out, become unconscious, or lost your memory?		
Have you ever had a seizure?		
Do you have frequent or severe headaches?		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
Have you ever had a stinger, burner, or pinched nerve?		
Have you ever become ill from exercising in the heat?		
Do you cough, wheeze, or have trouble breathing during or after activity?		
Do you have asthma?		
Do you have seasonal allergies that require medical treatment?		

	YES	NO
Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?		
Have you had any problems with your eyes or vision?		
Do you wear glasses, contacts, or protective eyewear?		
Have you ever had a sprain, strain or swelling after an injury?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check the appropriate box & explain below: _ Head _ Elbow _ Hip _ Neck _ Forearm _ Thigh _ Back _ Wrist _ Knee _ Chest _ Hand _ Shin/calf _ Shoulder _ Finger _ Ankle _ Upper arm _ Foot		
Do you want to weigh more or less than you do now?		
Do you lose weight regularly to meet weight requirements for your sport?		
Do you feel stressed out?		

Record the dates of your most recent immunizations (shots) for:
Tetanus________________ Measles______________
Hepatitis B __________ Chickenpox __________

FEMALES ONLY	
When was your first menstrual period?	
When was your most recent menstrual period?	
How much time do you usually have from the start of one period to the start of another?	
How many periods have you had in the last year?	
What was the longest time between periods in the last year?	

Explain "Yes" answers here:

MEDICAL HISTORY
List all medications you take and the reason you take them: 1. 2. 3. 4. 5. 6.
List any drugs, food, or airborne allergies you have: 1. 2. 3. 4. 5. 6.
List any Surgeries or Hospitalizations you have had: 1. 2. 3. 4. 5. 6.
List whether you wear corrective lenses, contacts, braces, retainers, or other appliances: 1. 2. 3. 4. 5. 6.

PATIENT INFORMATION							
Name		Sex		Age		Date of Birth	
Grade		School		Sport(s)			
Address				Phone			
Personal Physician							
In case of emergency, contact:							
Name		Relationship		Phone			

PHYSICAL EXAMINATION					
Height		Weight		% Body Fat (Optional)	
Pulse		BP	___/___ (___/___,___/___)		
Vision	R20/_____	Corrected:	Y OR N	Equal ______	Unequal ______

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

CLEARANCE			
☐	Cleared for participation		
☐	Cleared for participation after completing evaluation/rehabilitation: **For:**		
☐	Not cleared for participation **Reason:**		
Name of Physician		Date	
Facility address			
Signature of Physician			