Jr All American of Southern California Conference
Mandatory Medical Release Form
Chapter Name_____ Division_____

This form must be **dated AFTER March 25, 2022 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	6.	Are there any past surgeries/scheduled surgeries?	Yes / No
2.	Is the participant currently under the care of a doctor?	Yes/ No	7.	Is the participant currently taking any medication?	Yes / No
3.	Does the participant have any allergies (bee sting, penicillin)?	Yes/ No	8.	Does the participant have asthma/require inhaler	Yes / No
			9.	Does the participant wear glasses or contact lenses?	Yes/ No
4.	Is the participant diabetic/ require medication for Diabetes?	Yes/ No	10.	Does the participant have any physical limitation/ medical condition?	Yes/ No
5.	Does/ has the participant have/had seizures?	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's Name: _____

(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 2021 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: _____