



## GENERAL MEDICAL CLEARANCE FORM

Family Name: \_\_\_\_\_ Given Name(s): \_\_\_\_\_

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Date of Birth: (Day): \_\_\_\_ (Month): \_\_\_\_\_ (Year): \_\_\_\_\_

Permanent

Address: \_\_\_\_\_

*Street City Prov Postal Code*

Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Height: \_\_\_\_\_ Weight:

\_\_\_\_\_ lbs

Position: \_\_\_\_\_ (1<sup>st</sup> choice) \_\_\_\_\_ (2<sup>nd</sup> choice)

In case of an emergency notify:

Name(s): \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street City Prov Postal Code*

Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Family Doctor's Name: \_\_\_\_\_

Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## MEDICAL HISTORY

*Please check the appropriate answer:*

1. Yes  No  Do you have any allergies?

Please list: \_\_\_\_\_

2. Yes  No  Are you currently taking any medications?

List: \_\_\_\_\_

3. Yes  No  Are you taking any herbal preparations, supplements, vitamins? List:

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4. Yes  No  If "yes" to 5, have you suffered more than one concussion

How many? \_\_\_\_\_

5. Yes  No  Have you ever experienced amnesia or confusion after a concussion?

6. Yes  No  Have you ever had a "burner" or a "stinger"?

Dates: \_\_\_\_\_

7. Yes  No  Have you ever experienced an epileptic seizure or been informed you might have epilepsy? \_\_\_\_\_

8. Yes  No  Have you ever been treated for diabetes?

If "yes", what medication do you take?

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9. Yes  No  Have you ever had hepatitis?

Dates: \_\_\_\_\_

10. Yes  No  Have you ever had a peptic ulcer or gastritis?

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11. Yes  No  Have you ever been treated for or informed that you have had Rheumatic Fever or Scarlet Fever?

12. Yes  No  Have you ever been told that you have a heart murmur?

If "yes", do you take medication for it?

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13. Yes \_\_\_ No \_\_\_ Have you ever been treated for infectious mononucleosis, viral pneumonia, herpes, or any other infectious disease within the last 12 months?

Which: \_\_\_\_\_

14. Yes \_\_\_ No \_\_\_ Have you ever been told you have a hernia? If "yes", when was it repaired?

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15. Have you had any surgical operations within the past 2 years? If "yes", indicate what and dates:

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16. Yes \_\_\_ No \_\_\_ Are you currently under medical treatment for any problem? If "yes", indicate what:

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17. Yes \_\_\_ No \_\_\_ Have you ever been advised for medical reasons not to participate in certain activities/sports for any period? If "yes", give specifics:

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18. Yes \_\_\_ No \_\_\_ Are there any major illnesses in your family? Specify:

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19. Yes \_\_\_ No \_\_\_ Have you ever lost consciousness with exercise?

20. Yes \_\_\_ No \_\_\_ Have you ever experienced chest pain?

21. Yes \_\_\_ No \_\_\_ Have you ever felt lightheadedness with exercise?

22. Yes \_\_\_ No \_\_\_ Have you ever experienced exercise induced asthma?

Medication: \_\_\_\_\_

23. Yes \_\_\_ No \_\_\_ Have you ever had a neck or back injury? Specify nature and dates: \_\_\_\_\_

24. Yes \_\_\_ No \_\_\_ Do you experience frequent back pain? If yes, indicate frequency: very seldom\_\_\_ occasionally\_\_\_ frequently\_\_\_ only after vigorous exercise or heavy lifting\_\_\_

Yes \_\_\_ No \_\_\_ Have you ever had a shoulder injury?

Specifics: \_\_\_\_\_

25. Yes \_\_\_ No \_\_\_ Have you ever had an elbow injury?

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26. Yes \_\_\_ No \_\_\_ Have you ever had a wrist \_\_\_ hand \_\_\_ or arm \_\_\_ injury?

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27. Yes \_\_\_ No \_\_\_ Have you ever had a hip injury? \_\_\_\_\_

28. Yes \_\_\_ No \_\_\_ Have you ever had a knee injury? \_\_\_\_\_

29. Yes \_\_\_ No \_\_\_ Have you ever had an ankle injury? \_\_\_\_\_

30. Yes \_\_\_ No \_\_\_ Have you had a leg injury which has incapacitated you for a week or longer? If "yes" , specify: \_\_\_\_\_

31. Yes \_\_\_ No \_\_\_ Have you ever had a fracture/stress fracture within the last two years? Specifics: \_\_\_\_\_

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32. Yes \_\_\_ No \_\_\_ Have you ever had heat related problems in the past? \_\_\_\_\_

### **CERTIFICATION**

I certify that I have made full and complete disclosures concerning any and all illnesses, allergies, injuries, physical characteristics and conditions of my son / daughter, and I have answered completely and truthfully all questions asked of me within this form.

**Signature of Parent / Guardian:** \_\_\_\_\_

**Relationship to Participant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# RECOMMENDATION FROM MEDICAL QUESTIONNAIRE

**General**

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**Comments**

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**PASS** \_\_\_\_\_ **FAIL** \_\_\_\_\_

**PROVISIONAL** \_\_\_\_\_

**Is this athlete medically fit to participate in Football.**

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

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**Physician Address** \_\_\_\_\_

**Physician Signature** \_\_\_\_\_

The information is related directly to and needed by the Club to administer and operate the Program including registration, payment of fees and obtaining parental consent. The information will be used to apply parental consent and facilitate the provision of medical services in the event of an accident or injury to a participant. If you have questions about the collection and use of this information please contact the President of the Ardrossan Amateur Football Parents Association.