Jr All American of Southern California Conference
Mandatory Medical Release Form

Chapter Name_________________________ Division_____________________

This form must be **dated and physical performed AFTER March 22, 2024 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 by 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
2. **Is the participant currently under the care of a doctor?** Yes/ No
3. **Does the participant have any allergies (bee sting, penicillin)?** Yes/ No
4. **Is the participant diabetic/ require medication for Diabetes?** Yes/ No
5. **Does/ has the participant have/had seizures?** Yes/ No
6. **Are there any past surgeries/scheduled surgeries?** Yes / No
7. **Is the participant currently taking any medication?** Yes / No
8. **Does the participant have asthma/require inhaler** Yes / No
9. **Does the participant wear glasses or contact lenses?** Yes/ No
10. **Does the participant have any physical limitation/ medical condition?** 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:

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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 stationery 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:____
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_____**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 2024 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: _____________________________________