SEFFNER SEAHAWKS REGISTRATION FALL

CHEERLEADING ☐ FOOTBALL ☐ DIVISION: _____ RETURNING ☐

PARTICIPANT'S NAME:				
PARTICIPANT'S DATE OF BIRTH:		(Football) AGE AS OF **07/31/25**		
		(Cheer) AGE AS OF **08/31/25**		
PARTICIPANT'S PRIMARY HOME ADDRESS:	STREET			
	CITY:	STATE:	ZIP CODE:	
MAILING ADDRESS: (If different from above)	STREET			
	CITY:	STATE:	ZIP CODE:	
PARTICIPANT RESIDES WITH:	MOTHER ☐	FATHER ☐	BOTH ☐	OTHER:
NAME(S) OF PARENTS / GUARDIANS THAT PARTICIPANT RESIDES WITH:				
PHONE NUMBERS:	HOME:	CELL:		
	2ND HOME:	2ND CELL:		
EMERGENCY CONTACT NAME(S) INCLUDING CONTACT NUMBER(S): (**Other than above**)				
EMAIL ADDRESS(ES): (PLEASE WRITE CLEARLY).	@			
	@			
DID YOUR CHILD PLAY/CHEER FOR ANOTHER ORGANIZATION LAST YEAR:	YES ☐	NO ☐	IF YES, WHAT TEAM?	
OTHER SIBLINGS WITH THE SEAHAWKS:				
NAME:	AGE:	NAME:	AGE:	
NAME:	AGE:	NAME:	AGE:	

ALLGERGIES / ASTHMA TRIGGERS (Include any food allergies)	
CURRENT MEDICATION(S):	
YOUR NAME:	
RELATIONSHIP TO PARTICIPANT:	
SIGNATURE:	

*****ALL DEPOSITS / FEES COLLECTED ARE NON-REFUNDABLE*****

Total Fees Due: _____ ☐ Discount Amount Given: (_____) ☐ Payment Plan

Amount Paid: _____ Amount Owed: _____ Receipt #: _____ Payment Plan #: _____

Type of Payment: ☐ Check #: _____ ☐ Cash ☐ Money Order #: _____

Payment Received by: _____ Title: _____ Date: _____

Tri County Youth Football & Cheerleading Conference

Established 2013

PARTICIPANT REGISTRATION/INFORMATION FORM

Hillsborough County Florida

Child's Name _____ **DOB** _____
Last First Middle

Address _____ **Phone** _____

City/State/Zip _____

Emergency Contact _____
Name of Person Phone Number

School attending during season _____ Grade: _____

***Previous season affiliation** _____
Organization Child Played for last year

*Waiver may be required if child participated with an organization other than the one participant is registering for

PARTICIPATION RELEASE: I/We the parent(s)/legal guardian(s) of the above named child, hereby give my/our permission and approval for his/her participation in any and all Tri County Youth Football & Cheerleading Conference's activities during the current year. I/We assume all risks and hazards incidental to such participation, including transportation to and from the activities, including on premises supervision of all times. I/We do hereby waive, release, absolve, indemnify, and agree to hold harmless and blameless the organizers, sponsors, supervisors, officers, Board of Trustees, coaches, trainers, and other volunteer persons, for any claim arising out of an injury to my/our child, including transportation to and from activities, except to the extent and in the amount covered by organization or association provided accident or liability insurance, if any.

MEDICAL TREATMENT PERMISSION: I/We, the parent(s)/guardian(s) of the above named child, authorize a physician of an licensed and certified hospital or emergency facility, the nurses and assistants, and/or other medical personnel to perform all treatment and procedures as ordered and deemed necessary as a result of any injury sustained by any child.

EQUIPMENT RETURN AGREEMENT: I/We, the parent(s)/guardian(s) of the above named child, agree that all equipment and uniforms issued to my/our child will be properly cared for and returned to the organization in the same condition as when issued, normal wear and tear excepted, upon the conclusion of the current season or at the time my/our child ceases participation during the current season, or at such time that the organization shall request it return. If such equipment is not returned as stated above, I/We agree to pay to the organization total replacement cost of all equipment and uniforms issued to my/our child.

I/We understand each organization within the Tri County Youth Football & Cheerleading Conference determines it own registration fees and these fees may be non-refundable. This fee is payable before my/our child is allowed to start practice. It is also required that all participants complete a sports physical by a certified physician after May 1st of the season of participation. I/We attest to the fact that I/We have furnished the organization a certified copy of my/our child's birth certificate or other certifiable proof of date of birth. I/We declare all documentation to be forthright and without misrepresentation.

Attach
Current photo
here

I/We have read this form, certify the information provided is accurate, and agree with all the above conditions.

Parent/Guardian Date

Parent/Guardian Date

Notary Date

Seal of Notary Public

For Organization Use Only

Staple Physician's Sports Physical Statement Here

Age _____ **Weight** _____ **Team** _____
As of July 31st

Emergency Contact

_____
Phone Number other than home

Allergies/Medical Problems _____

Fees Paid _____
Amount Receipt No. Date

Amount Receipt No. Date

Amount Receipt No. Date

Miscellaneous _____

********Organization Use Only*********

I CERTIFY THE INFORMATION CONTAINED HEREIN TO BE TRUE AND EXACT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF ORGANIZATION OFFICIAL

TITLE DATE

The Tri County Youth Football & Cheerleading Conference and its member Organizations assumes no responsibility for typographical error or other situations beyond their control.

T.C.Y.F.C.C.
Informed Consent about Concussions and Head Injuries

Effective July 1st, 2012 Florida Statute 943.0438 requires the parent or guardian and the youth who is participating in athletic competition or who is a candidate for an athletic team to sign and return an informed consent that explains the nature and risk of concussion and head injury, each year before participating in athletic competition or engaging in any practice, tryout, workout, or other physical activity associated with the youth's candidacy for an athletic team.

The Facts:

- A concussion is a brain injury.
- All concussions are serious.
- Concussions can occur without the loss of consciousness.
- Concussions can occur in any sport.
- Recognition and proper management of concussions when they first occur can help prevent further injury or even death.

What is a concussion? A concussion is an injury that changes how the cells in the brain normally work. A concussion is caused by a blow to the head or body which causes the brain to move rapidly inside the skull. Even a "Ding", "Getting your bell rung", or what seems like a mild bump or blow to the head can be serious. Concussions can also result from a fall or players colliding with each other or obstacles, such as a goal post, even if they do not directly hit their head.

To help recognize a concussion, you should watch for the following signs in your athletes:

1. A forceful blow to the head or body that results in rapid movement of the head. -and-
2. Any change in the athlete's behavior, thinking, or physical functioning.

Signs and symptoms of concussion that may be reported by a coach or other observer:

- Appears dazed or stunned.
- Is confused about assignment or position.
- Forgets sports plays.
- Is unsure of game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness(even briefly)
- Can't recall events prior to hit or fall.

Signs and symptoms that may be reported by the player:

- Headache or pressure in the head.
- Nausea or vomiting.
- Balance problems or dizziness.
- Double or blurry vision.
- Sensitivity to light.
- Sensitivity to noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Concentration or memory problems.
- Confusion.
- Does not feel right.

Both parents/guardians and players are advised to take the Center for Disease Control's free online concussion training at http://www.cdc.gov/concussion/HeadsUp/Training/HeadsUpConcussion.html

Under Florida law the player who is suspected of having a concussion or head injury must be removed from play or practice. Before the player may return to practice or competition a written medical clearance to return stating the athlete no longer exhibits signs, symptoms, or behaviors consistent with a concussion or other head injury must be received from an appropriate health care professional trained in the diagnosis, evaluation, and management of concussions. In Florida, an appropriate health care professional (AHCP) is defined as either licensed physician(MD as per Chapter458, Florida Statutes) a licensed physicians assistant under the supervision of a MD/DO(as per Chapters 458.347 and 459.022, Florida statutes) or a health care professional trained in the management of concussions.

I have read and understand this consent form, and I volunteer to participate.

Player Name:_____

Signature:_____ Date:_____

As parent or guardian, I have read and understand this consent form and give permission for my child named above to participate.

Parent/Legal Guardian Name:_____

Signature: _____ Date:_____

TRI-COUNTY YOUTH FOOTBALL AND CHEERLEADING CONFERENCE (TCYFCC)

WAIVER AND RELEASE OF LIABILITY

In consideration of being permitted to utilize the facilities, services and programs of the TCYFCC (or for my children to so participate) for any purpose, including, but not limited to observation or use of facilities or equipment, or participation in any off-site program affiliated with the TCYFCC, the undersigned, for himself or herself and such participating children and any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has, or immediately upon entering or participating will, inspect and carefully consider such premises and facilities or the affiliated program. It is further warranted that such entry into the TCYFCC for observation or use of any facilities or equipment or participation in such affiliated program constitutes an acknowledgment that such premises and all facilities and equipment thereon and such affiliated program have been inspected and carefully considered and that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use or participation by the undersigned and such children.

In further consideration of being permitted to enter the TCYFCC for any purpose including, but not limited to observation or use of facilities or equipment, or participation in any off-site program affiliated with the TCYFCC, the undersigned hereby agrees to the following:

1. THE UNDERSIGNED ON HIS OR HER BEHALF AND BEHALF OF SUCH CHILDREN, HEREBY RELEASES, WAIVES, DISCHARGES AND CONVENTS NOT TO SUE TCYFCC and all branches thereof, its directors, officers, employees, and agents (hereinafter referred to as "releasees") from all liability to the undersigned or such children and all his personal representatives, assigns, heirs, and next of kin for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned or such children whether caused by the negligence of the releasees or otherwise while the undersigned or such children is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with TCYFCC.

2. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releasees and each of them from any, loss, liability, damage or cost they may incur due to the presence of the undersigned or such children in, upon, or about TCYFCC premises or in any way observing or using any facilities or equipment of TCYFCC or participating in any program affiliated with TCYFCC whether caused by the negligence of the releasees or otherwise.

3. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH, OR PROPERTY DAMAGE to the undersigned or such children due to the negligence of releasees or otherwise while in, about or upon the premises of TCYFCC and/or while using the premises or any facilities or equipment thereon or participating in any program affiliated with TCYFCC.

Dated: _____ _____

Printed Name of Parent/Guardian

_____ _____

Participant Name Signature of Parent/Guard

STATE OF FLORIDA; COUNTY OF _____

SWORN TO AND SUBSCRIBED before me on this the _____day of _____ 20___, by _____, who is either personally known to me or provided _____ as identification and who did take an oath.

_____

Notary Public

PREPARTICIPATION PHYSICAL EVALUATION (Page 1 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/23

MEDICAL HISTORY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___/___/_____
School: _____ Grade in School: _____ Sport(s): _____
Home Address: _____ City/State: _____ Home Phone: (_____) _____
Name of Parent/Guardian: _____ E-mail: _____
Person to Contact in Case of Emergency: _____ Relationship to Student: _____
Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____
Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

List past and current medical conditions:

_____

Have you ever had surgery? If yes, please list all surgical procedures and dates:

_____

Medicines and supplements (please list all current prescription medications, over-the-counter medicines, and supplements (herbal and nutritional):

_____

Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, insects):

_____

Patient Health Questionaire version 4 (PHQ-4)

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle response)

	Not at all	Several days	Over half of the days	Nearly everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

	GENERAL QUESTIONS Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.	Yes	No
1	Do you have any concerns that you would like to discuss with your provider?		
2	Has a provider ever denied or restricted your participation in sports for any reason?		
3	Do you have any ongoing medical issues or recent illnesses?		
	HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4	Have you ever passed out or nearly passed out during or after exercise?		
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7	Has a doctor ever told you that you have any heart problems?		

	HEART HEALTH QUESTIONS ABOUT YOU *(continued)*	**Yes**	**No**
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography (ECHO)?		
9	Do you get light-headed or feel shorter of breath than your friends during exercise?		
10	Have you ever had a seizure?		
	HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35? (including drowning or unexplained car crash)		
12	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminerigc polymorphic ventricular tachycardia (CPVT)?		
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

This form is not considered valid unless all sections are complete.

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

EL2
Revised 4/23

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

BONE AND JOINT QUESTIONS		Yes	No
14	Have you ever had a stress fracture?		
15	Did you ever injure a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
16	Do you have a bone, muscle, ligament, or joint injury that currently bothers you?		

MEDICAL QUESTIONS		Yes	No
17	Do you cough, wheeze, or have difficulty breathing during or after exercise or has a provider ever diagnosed you with asthma?		
18	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
19	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
20	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant staphylococcus aureus (MRSA)?		
21	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
22	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
23	Have you ever become ill while exercising in the heat?		
24	Do you or does someone in your family have sickle cell trait or disease?		
25	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS *(continued)*		Yes	No
26	Do you worry about your weight?		
27	Are you trying to or has anyone recommended that you gain or lose weight?		
28	Are you on a special diet or do you avoid certain types of foods or food groups?		
29	Have you ever had an eating disorder?		

Explain "Yes" answers here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

This form is not considered valid unless all sections are complete.

Participation in high school sports is not without risk. The student-athlete and parent/guardian acknowledge truthful answers to the above questions allows for a trained clinician to assess the individual student-athlete against risk factors associated with sports-related injuries and death. Florida Statute 1006.20 requires a student candidate for an interscholastic athletic team to successfully complete a preparticipation physical evaluation as the first step of injury prevention. This preparticipation physical evaluation shall be completed each year before participating in interscholastic athletic competition or engaging in any practice, tryout, workout, conditioning, or other physical activity, including activities that occur outside of the school year.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine physical evaluation required by Florida Statute 1006.20, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test. The FHSAA Sports Medicine Advisory Committee strongly recommends a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include the special tests listed above.

Student-Athlete Name: _____ *(printed)* Student-Athlete Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___ / ___ / ___

Parent/Guardian Name: _____ *(printed)* Parent/Guardian Signature: _____ Date: ___ / ___ / ___

PREPARTICIPATION PHYSICAL EVALUATION (Page 3 of 4)

This medical history form should be retained by the healthcare provider and/or parent.
This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/23

PHYSICAL EXAMINATION FORM

Student's Full Name: _____ Date of Birth: ___ /___ /_____ School: _____

PHYSICIAN REMINDERS:

Consider additional questions on more sensitive issues.

• Do you feel stressed out or under a lot of pressure?	• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?	• During the past 30 days, did you use chewing tobacco, snuff, or dip?
• Do you drink alcohol or use any other drugs?	• Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?	

☐ Verify completion of FHSAA EL2 Medical History (pages 1 and 2), review these medical history responses as part of your assessment. Cardiovascular history/symptom questions include Q4-Q13 of Medical History form. *(check box if complete)*

EXAMINATION			
Height:	**Weight:**		
BP: / (/)	**Pulse:**	**Vision:** R 20/ L 20/	**Corrected:** Yes No

MEDICAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, Ears, Nose, and Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus (HSV), lesions suggestive of Methicillin-Resistant Staphylococcus Aureus (MRSA), or tinea corporis		
Neurological		

MUSCULOSKELETAL - healthcare professional shall initial each assessment	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and Arm		
Elbow and Forearm		
Wrist, Hand, and Fingers		
Hip and Thigh		
Knee		
Leg and Ankle		
Foot and Toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

This form is not considered valid unless all sections are complete.

*Consider electrocardiography (ECG), echocardiography (ECHO), referral to a cardiologist for abnormal cardiac history or examination findings, or any combination thereof. The FHSAA Sports Medicine Advisory Committee strongly recommends to a student-athlete (parent), a medical evaluation with your healthcare provider for risk factors of sudden cardiac arrest which may include an electrocardiogram.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___ / ___ / _____

Address: _____ Phone: (_____) _____ E-mail: _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

PREPARTICIPATION PHYSICAL EVALUATION (Page 4 of 4)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/23

MEDICAL ELIGIBILITY FORM

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___/___/_____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Recommendations: *(use additional sheet, if necessary)*

_____

I hereby certify that I have examined the above-named student-athlete using the FHSAA EL2 Preparticipation Physical Evaluation and have provided the conclusion(s) listed above. A copy of the exam has been retained and can be accessed by the parent as requested. Any injury or other medical conditions that arise after the date of this medical clearance should be properly evaluated, diagnosed, and treated by an appropriate healthcare professional prior to participation in activities.

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/_____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

SHARED EMERGENCY INFORMATION - completed at the time of assessment by practitioner and parent

☐ Check this box if there is no relevant medical history to share related to participation in competitive sports.

Provider Stamp *(if required by school)*

Medications: *(use additional sheet, if necessary)*

List: _____

_____

Relevant medical history to be reviewed by athletic trainer/team physician: *(explain below, use additional sheet, if necessary)*

☐ Allergies ☐ Asthma ☐ Cardiac/Heart ☐ Concussion ☐ Diabetes ☐ Heat Illness ☐ Orthopedic ☐ Surgical History ☐ Sickle Cell Trait ☐ Other

Explain: _____

_____

Signature of Student: _____ Date: ___/___/___ Signature of Parent/Guardian: _____ Date: ___/___/___

We hereby state, to the best of our knowledge the information recorded on this form is complete and correct. We understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (ECG), echocardiogram (ECHO), and/or cardio stress test.

This form is not considered valid unless all sections are complete.

PREPARTICIPATION PHYSICAL EVALUATION (Supplement)

SUBMIT THIS MEDICAL ELIGIBILITY FORM TO THE SCHOOL

This form is valid for 365 calendar days from the date signed below.

EL2

Revised 4/23

This form is only used, or requested, if a student-athlete has been referred for additional evaluation, prior to full medical clearance.

MEDICAL ELIGIBILITY FORM - Referred Provider Form

Student Information (to be completed by student and parent) *print legibly*

Student's Full Name: _____ Sex Assigned at Birth: _____ Age: _____ Date of Birth: ___/___/_____

School: _____ Grade in School: _____ Sport(s): _____

Home Address: _____ City/State: _____ Home Phone: (_____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____ Relationship to Student: _____

Emergency Contact Cell Phone: (_____) _____ Work Phone: (_____) _____ Other Phone: (_____) _____

Family Healthcare Provider: _____ City/State: _____ Office Phone: (_____) _____

Referred for: _____ Diagnosis: _____

I hereby certify the evaluation and assessment for which this student-athlete was referred has been conducted by myself or a clinician under my direct supervision with the conclusions documented below:

☐ Medically eligible for all sports without restriction as of the date signed below

☐ Medically eligible for all sports without restriction after completion of the following treatment plan: *(use additional sheet, if necessary)*

_____

☐ Medically eligible for only certain sports as listed below:

_____

☐ Not medically eligible for any sports

Further Recommendations: *(use additional sheet, if necessary)*

_____

Name of Healthcare Professional (print or type): _____ Date of Exam: ___/___/_____

Address: _____ Phone: (_____) _____

Signature of Healthcare Professional: _____ Credentials: _____ License #: _____

Provider Stamp *(if required by school)*