



MEDICAL CLEARANCE FORM

PARTICIPANT'S NAME: _____

Has the Participant been treated for, or had any known indication of:

		YES	NO
1	Disorder of eyes, ears, nose, or throat?	<input type="checkbox"/>	<input type="checkbox"/>
2	Dizziness, Fainting, Convulsions, Paralysis, or Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
3	Bronchitis, Asthma, Pleurisy, or Respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
4	High Blood Pressure, Rheumatic Fever, or Heart Murmur?	<input type="checkbox"/>	<input type="checkbox"/>
5	Jaundice, Hernia, Appendicitis, or Intestinal Bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
6	Sugar, Albumin, Blood, or Pus in Urine?	<input type="checkbox"/>	<input type="checkbox"/>
7	Diabetes, Thyroid, or other Endocrine disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8	Neuritis, Arthritis, or other disorder of the muscles or bones?	<input type="checkbox"/>	<input type="checkbox"/>
9	Deformity, Lameness, or Amputation?	<input type="checkbox"/>	<input type="checkbox"/>
10	Disorder of skin, Lymph Glands, cysts, tumors, or Cancer?	<input type="checkbox"/>	<input type="checkbox"/>
11	Allergies, Anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12	Use of alcohol, tobacco, or any habit-forming drugs?	<input type="checkbox"/>	<input type="checkbox"/>
13	Any excessive weight change in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
14	Are you now under a Doctor's care or taking medications? (explain)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Other than the above, within the last 3 years, has the participant:</i>			
15	Had an illness, injury, or any surgery? (explain)	<input type="checkbox"/>	<input type="checkbox"/>
16	Been a patient in a hospital, clinic, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
17	Is there a history of Tuberculosis, Diabetes, Cancer, Heart Disease, Mental Illness or Suicide?	<input type="checkbox"/>	<input type="checkbox"/>
<i>Explanations:</i>			

DOCTOR'S DECLARATION

I declare the above named participant is fit to participate in the Hudson County Youth Football League (HCYFL).

Doctor's Name: _____

Doctor's Signature: _____

Date: _____