Guam National Youth Football Federation

MEDICAL CLEARANCE

Player's Name _____ (Last / First / Middle Initial) DATE OF BIRTH _____ (Month / Day / Year)

SEX: ☐ Female ☐ Male GRADE: _____ SCHOOL: _____

MEDICAL INSURANCE: _____ POLICY # _____

PRIMARY PHYSICIAN: _____

CLINIC INFORMATION: _____ (Name / Location / Telephone)

MEDICAL HISTORY COMPLETED BY PARENT/GUARDIAN

Does child have:			*if yes, please specify:*
An ongoing or chronic illness?	☐ No	☐ Yes	
Any allergies to food or medicine?	☐ No	☐ Yes	
Any heart problems?	☐ No	☐ Yes	
A history of convulsions or seizures?	☐ No	☐ Yes	
Any physical disabilities?	☐ No	☐ Yes	
Medication on a regular basis?	☐ No	☐ Yes	
Has child ever had surgery?	☐ No	☐ Yes	

To the best of my knowledge, my answers to the above questions are complete and correct.

Player's Signature _____ Parent/Guardian Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN

Height _____ ft. _____ in.
Weight _____ lbs.
Temperature _____
Pulse _____
Respiration _____
Blood Pressure _____
Vision Right Eye _____
Left Eye _____
Hearing Right Ear _____
Left Ear _____

General Examination

Head	_____	Heart	_____
Eyes	_____	Chest	_____
Ears	_____	Lungs	_____
Nose	_____	Abdomen	_____
Mouth	_____	Spleen	_____
Neck	_____	Hernia	_____
Throat	_____	Genitals	_____
Teeth	_____	Extremities	_____
Skin	_____	Neurological	_____

Any significant physical, mental, emotional, or social problems that may interfere with the child's participation?
☐ Yes ☐ No *Comments:* _____

MEDICAL EXAMINER'S CLEARANCE

☐ Cleared
☐ Not Cleared

Physician's Signature _____ Date of Examination _____
Physician's Name (print/type) _____ Phone Number _____

GNYFF requires original physician signature & stamp - photocopies will NOT be accepted.