



Conference / Association Name: Hudson Hawks

MEDICAL CLEARANCE FORM

I, _____, by my signature below, do certify that I am licensed by the state of Ohio and am qualified in determining that, based on a full physical examination made by me on _____, 20____ and (if applicable) my examination today, _____, 20____ (insert Participant's name) _____ is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating in youth flag football, tackle football, cheer, dance or any other athletic activity(s). I am therefore clearing this individual for Full Unrestricted Athletic Participation for the youth football season ending on or about November 1, 2017.

	<i>Please Print – or – Use Office Stamp Here:</i>
Medical Professional Signature / /	Print Name Clearly
Date – Must be dated after January 1 st of the Current Season	Office Address/Phone

PLEASE NOTE: If this Medical Clearance is voided by injury, accident, illness, and/or the participant is removed from any participation as a result of a suspected concussion or heat related illness, it will be the responsibility of the Parent/Legal Guardian to notify the participants Coach and League Officials. It will also be the responsibility of the Parent / Legal Guardian to obtain WRITTEN permission from his/her physician to resume participation. If the injury is a concussion or suspected concussion, the attached "Medical Clearance to Return to Play After Suspected Concussion" must be completed and returned. Otherwise, a "Doctors Resume Participation Medical Clearance Form" is available from the league **OR** you may have the doctor supply his/her own WRITTEN Clearance as long as it is on the doctor's official stationary and includes the following statement: "**[Participants Name] is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from RESUMING participating in youth flag football, tackle football, cheer, dance or any other athletic activity(s). I am therefore clearing this individual for Full Unrestricted Athletic Participation.**" This statement must be supplied by the physician and/or athletic trainer (if a physician, physician's assistant or nurse practitioner) attending to the Participant.

This form can be modified or substituted ONLY to comply with local and/or state laws or due to medical practitioner regulations.

Note: This form should be kept on file for a minimum of 7 years, longer in the event of an injury.