Jr All American of Southern California Conference
Mandatory Medical Release Form

Chapter Name_____ Division_____

This form must be **dated and physical performed AFTER March 21, 2025 AND within 4 months prior to first day of practice.** This form must be 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	6.	Are there any past surgeries/scheduled surgeries?	Yes / No
2.	Is the participant currently under the care of a doctor?	Yes/ No	7.	Is the participant currently taking any medication?	Yes / No
3.	Does the participant have any allergies (bee sting, penicillin)?	Yes/ No	8.	Does the participant have asthma/require inhaler	Yes / No
			9.	Does the participant wear glasses or contact lenses?	Yes/ No
4.	Is the participant diabetic/ require medication for Diabetes?	Yes/ No	10.	Does the participant have any physical limitation/ medical condition?	Yes/ No
5.	Does/ has the participant have/had seizures?	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:

_____

_____

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:_____

_____

_____**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 the 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 2025 season. I am therefore clearing this individual for athletic participation without limitation.**

Signed _____ Print Name: _____

Date: _____ **Date Physical was actually performed:** _____

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 from one.

Address: _____ Mandatory Dr. Stamp Here:

City: _____ State: _____

Telephone: _____