Team Prime Time

Medical Information And Clearance Form

Child's Name ____ Date ___________ Age ___________ DOB ___________

THIS SECTION IS TO BE COMPLETED BY A PARENT OR GUARDIAN

Please list your child's dietary restrictions: ____

Please list your child's food allergies:____

Please list your child's medication allergies: ____

Please indication which of the following medical conditions your child has, or has had:

Asthma: _____ Diabetes: _____ Hay Fever: _____ Seizures: _____ ADHD/ADD: _____ Autism: _____

Heart Condition: _____ Kidney Condition: _____ Orthopedic Condition: _____

Physical Disability (if yes, please describe):____

OTHER: ____

________________________________ ________________________________ ________________

Parent/Guardian's Name (please print) Parent/Guardian's Signature Date

________________________ ________________________________

Day Time Telephone Number Cell Phone (if different than day time number)

THIS SECTION IS TO BE COMPLETED BY A LICENSED PHYSICIAN

Nature of injury or medical condition:

____

____

PARTICIPATION RECOMMENDATIONS:

No participation: ____

Limited participation: ____

Requires: ____

Full participation: ____

________________________________ ________________________________ ________________

Physician's Name (please print) Physician's Signature Date

________________________________ ________________________________

Address Telephone Number