Medical Information and Clearance Form

Team Prime Time

Students's Name ____ Date ___________

Age ___________ DOB ___________

My child has the following **food allergies:**

____

My child has the following **medication allergies:**

____

Nature of injury or medical condition:

____

____

PARTICIPATION RECOMMENDATIONS:

No participation:

____

Limited participation:

____

Requires:

____

Full participation:

____

________________________________	________________________________
Physician's Name (please print)	Physician's Signature
________________________________	________________________________
Address	Telephone Number