Summerville Miracle League Player Medical History & Physician Clearance Form:

Player's Name: _____ Date of Birth: _____

Home Address: _____

Home Phone: _____ Alternate Phone: _____

Name of Parent(s)/Guardian(s):_____

Medical Diagnosis: _____

Medical Information:

Tetanus Shot: __ no ___yes If yes, date of last shot: _____

Seizures: __no __yes If yes, are seizures controlled by medication? _____ Date of last seizure: _____

Medications player is currently taking (attach second sheet if necessary):

_____

Please indicate if the player has a problem and/or surgeries in any of the following areas by checking YES or NO. If YES please comment (attach second sheet if necessary):

AREA	**NO**	**YES**	**COMMENT**
Auditory	☐	☐	_____
Visual	☐	☐	_____
Speech	☐	☐	_____
Circulatory/Cardiac	☐	☐	_____
Pulmonary/respiratory/asthma	☐	☐	_____
Neurological	☐	☐	_____
Muscular	☐	☐	_____
Orthopedic	☐	☐	_____
Allergies	☐	☐	_____
Learning Disability	☐	☐	_____
Mental Impairment	☐	☐	_____
Psychological	☐	☐	_____
Impairment/behavioral	☐	☐	_____
Other	☐	☐	_____

Mobility:

Please indicate the player's primary mode for moving in the community:

__ walking independently
__ walking with help from caregiver
__ walking using an assistive device (ie. walker, crutches)
__ wheelchair user

Please indicate any other special precautions or equipment used by player when moving in community settings:

_____

<u>Physician Statement – signature required</u>:

Based on my knowledge of this patient, he/she is medically cleared to participate in the Summerville Miracle League.

Physician's Name (please print): _____

Signature: _____ Date:_____

Address of Physician's office: _____

Phone: _____ Fax: _____ Email: _____