Foothill Farms Little League

Medical Release

Name of Participant: ______________________________________
Age: ____ Date of Birth:________________
Athlete's address: ____
Contact person in case of emergency:
Name: ______________________ Phone: __________ relationship: ________________
Name: ______________________ Phone: __________ relationship: ________________
Name: ______________________ Phone: __________ relationship: ________________
Name: ______________________ Phone: __________ relationship: ________________

Medical Health Plan: _______________________ Medical Record Number: ___________
Primary physician: _________________________ Phone number: __________________
Office location: ______________________ Hospital preference: __________________

Dentist: ___________________ Phone number: ________________________
Office location: ______________________ Dental insurance number: _______________

Has participant ever participated in this or other equally vigorous events before? Yes/No
Which events? When? Did they have problems during or after participation?

______________ ______ ____
______________ ______ ____

Were they ever kept out of sports or athletic events or physical activity? Yes/No
When? _______ What activity: ___________________ Why? ______________________
Are they currently under a doctor's care for medical conditions? ___________________
Which Doctor? ___________________
Please list medical conditions and current treatments:
____
____

Please list:

ALLERGIES____
MEDICATIONS________________________REACTION:__________________
LATEX: YES/NO REACTION: ____
INSERT BITES: YES/NO which insect: ____________REACTION:_________
___I have an EPIPEN ___ I know how to use an EPIPEN ___ I have had to use an EPIPEN

Current MEDICATIONS:	Dosages	Times per day	Reason
Inhaler: ________________	__________	________________	_______________
Insulin: ________________	__________	________________	______________
______________________	___________	_________________	______________

Check all that apply:

__ I/We believe immunizations are up to date.
__ had previous surgery of the head
__ had previous surgery of arm/hand
__ had previous surgery of chest/lung/heart
__ had previous surgery of eye/ear/nose/mouth/jaw
__ Sickle cell disease (family history)
__ History of pulmonary embolism
__ loose teeth
__ implants in mouth
__ lung problems
__ sleep apnea
__ asthma
__ shortness of breath at rest
__ back problem
__ neck problem
__ abdominal problems
__ heart problems
__heart defect
__ liver problem
__ hypertension
__ inflammatory disease
__ endocrine disorder
__ kidney problems
__ previously removed or non-functioning kidney
__ genital injury or problem
__ testicle problem
__ ovarian problem
__ lost ovary or non-functioning
__ lack of menstruation periods
__ use hearing aid
__ blindness or vision loss in one eye
__ uses contact lenses or glasses
__ headaches
__ ever had a concussion
__ dizziness or fainting spells
__ paralysis or one-sided weakness
__ serious illness
__ history of emotional/behavioral problems
__ had previous surgery of spine
__ had previous surgery of leg/foot
__ had previous surgery of abdomen
__ history of blood clots
__ bleeding or clotting problems
__ difficulty opening mouth
__ braces
__ use of mouth guard
__ reactive airway disorder
__ chest pain
__ shortness of breath with exercise
__ spine problem
__ neck instability
__ cancer now or in the past
__ had spleen removed
__ have a pacemaker or defibrillator
__ heat stroke or exhaustion
__ hepatitis/AIDS/HIV
__ vascular problems
__ arthritis
__ diabetes
__ on dialysis
__ ever had urinary tract problems
__ pelvic or groin problem
__ lost a testicle
__ tube problem/injury/surgery
__ irregular menstrual periods
__ hearing problems
__ vision problems
__ uses sports glasses or goggles
__ neurologic disorder
__ had a stroke
__ serious head injury
__ epilepsy/seizures
__ ever broken a bone
__ major surgery
__ history of eating disorders

If yes to any, please explain: ____

____

Other medical problems: ____
Any family history we should be aware of: _______________________________________

___________________________________ _____________
Signature Date