Physical Examination Information

Date_____/_____/_____

Name of Participant: _____ **Age:** _____ **Birth date:** _____/_____/_____

Each participant must **EITHER** attach a copy of a physician conducted sports examination applicable to this current academic year **OR** have a physician complete and then sign the form below.

Clearance: (circle one)

A. Cleared

B. Cleared after completing evaluation / rehabilitation for: _____

C. Not cleared for:

☐**Non-contact:** ☐Strenuous ☐Moderately strenuous ☐Non-strenuous

Due to: _____

Recommendation: _____

_____

_____

Signature of Physician: _____ **Date:** _____/_____/_____

Physician's Address: _____

Physician's Phone: _____

Five Star Flag Football

Website: www.fivestarflagfootball.com
E-mail: info@fivestarflagfootball.com
Phone: 781-727-2664

Five Star Flag Football Release Waiver

WAIVER, RELEASE, ASSUMPTION OF RISK

I understand that my participation in any programs owned and operated by Five Star Flag Football, involves Risk and dangers of serious and permanent bodily injury and death. I, or my parent/guardian if I am a minor, hereby release, hold harmless, discharge and agree not to sue the Five Star Flag Football LLC or it's partners, affiliates, and staff, Five Star Flag Football, Officials, Coaches, Volunteers, Agents, Sponsors, Advertisers, Owners/Leasers of Premises for all liability from my participation in these and any other related travel, lodging, social/recreational activities. I also understand Five Star Flag Football LLC retains the right to use for publicity and advertising, photographs and video taken of the participants. Lastly, I understand that Five Star Flag Football LLC programs are independently owned and operated, and are in no way affiliated with Brandeis University or the town of Waltham, Massachusetts.

Medical Release

I have given my daughter/ son permission to participate in the Five Star Flag Football LLC athletic or academic programs, and I certify that she/he is in good health and can take part in all activities. If an injury occurs, I authorize the staff members to take all proper action and use the emergency service available at the nearest hospital if necessary. I understand my personal insurance will be used in this case. In case of an emergency, I authorize the personnel to take action.

Participant's name:_____

Parent / guardian signature:_____

Home phone #:_____

Cell phone #:_____

Work phone #:_____

Bring this signed form on the first day. (You may scan and e-mail it.)

Each child must have a signed copy on file.

HEALTH INSURANCE INFORMATION SHEET

EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE

Private insurance information must be provided, if applicable. Please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant's Name: _____

Participant's Address: _____

Participant's Phone Number: _____

Date of Birth: _____

Insurance Company: _____ Effective Date: _____

Address of Insurance Company: _____

Phone Number of Insurance Company: _____ Group #:_____

Policyholder's Name: _____ Policy #:_____

Policyholder's Address: _____

Relationship to Participant: _____

Contract #:_____ Employee #: _____

I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for all costs not paid by my medical insurance program.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

EMERGENCY INFORMATION AND CONTACTS

Please complete this form in its entirety. This information will be helpful in the unlikely event of an accident or sudden illness.

Name of Personal Physician: _____ Phone: _____

Physician's Address: _____

Person(s) to be contacted in case of Emergency:

Name: _____ Relationship: _____
Address: _____
Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____
Address: _____
Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

Summer Health Questionnaire

(To be filled out by Participant's Parent or Guardian)

Participant: _____ **Birth date:** _____/_____/_____ **Sex:** M F

Address: _____ **Phone:** ( ) _____-_____

Family Physician: _____ **Phone:** ( ) _____-_____

Parent/Guardian name(s): _____

Medications: indicate medication(s) which taken on a regular basis:

Medication Name: _____ Dosage: _____ Directions: _____

Medication Name: _____ Dosage: _____ Directions: _____

Note: Participant should bring an adequate supply of their medication(s) with them.

Explain any "yes" answers below:	**Yes**	**No**
Nervous System: Has the participant ever:		
1. had a head injury?	☐	☐
2. been knocked out or unconscious?	☐	☐
3. had a seizure?	☐	☐
4. had a stinger, burner, or pinched nerve?	☐	☐
5. had any problems with his/her eyes or vision?	☐	☐
6. worn glasses, contacts or protective eyewear?	☐	☐
Circulation: Has the participant ever:		
7. been dizzy or passed out during or after exercise?	☐	☐
8. had chest pain during or after exercise?	☐	☐
9. tired out more quickly than their friends during exercise?	☐	☐
10. been told he/she has a heart murmur?	☐	☐
11. had racing heart or skipped heartbeats?	☐	☐
12. had anyone in their family died of heart problems or sudden death before age 50?	☐	☐
Respiratory:		
13. Does the participant ever have trouble breathing or cough during or after exercise?	☐	☐
Musculoskeletal:		
14. Does he/she frequently have heat or muscle cramps?	☐	☐
15. Does he/she use any special equipment (pads, braces, neck rolls, mouth guards, etc.)?	☐	☐
16. Has she/he had any injuries of any bones or joints?	☐	☐
☐ Head ☐ Chest ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Neck ☐ Back ☐ Forearm ☐ Hand ☐ Thigh ☐ Calf ☐ Foot		
17. **Skin:** Does she/he have any skin problems (itching, rashes, acne, etc.)?	☐	☐
General:		
18. Has he/she ever had surgery or been hospitalized?	☐	☐
19. Has he/she had any other medical problems (infectious mono, diabetes, high blood pressure, etc.)?	☐	☐
20. Is he/she taking any medications or pills?	☐	☐
21. Does he/she have any allergies (medicines, bees or other stinging insects)?	☐	☐
22. When was the participant's last tetanus shot?_____		
23. When was the participant's last measles immunization?_____		

Explain "Yes" answers:

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Participant: _____ **Date:** _____/_____/_____

Signature of Parent/Guardian: _____ **Date:** _____/_____/_____