TRI STATE ELITE

Medical Clearance Form

Athlete Information

Participant Name | Date of Birth

Address

City | State: | Zip:

Address | Email

Activity | Team

Emergency Contact: | Emergency Phone:

Medical History (Check all that apply)

- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Condition
- ☐ Seizures/Epilepsy
- ☐ High Blood Pressure
- ☐ Concussion History
- ☐ Joint/Bone Injury
- ☐ Allergies
- ☐ Surgery (past 12 months)
- ☐ Currently on Medication
- ☐ Other (explain below)

If other, please explain:

Physician Clearance

I have examined the above-named athlete and find them:

- ☐ Cleared for full participation without restriction
- ☐ Cleared with the following restrictions (see below)
- ☐ Not cleared for participation at this time

Restrictions/Comments:

Physician Information

Signature:

Date:

Must be dated after January 1st 2026

Office Stamp Here in this box

Parent/Guardian Consent (if athlete is under 18)

I hereby give consent for my child to participate in athletic activities as cleared above and authorize emergency medical treatment if necessary.

Parent/Guardian Signature **Date**