

Player Name _____

Season _____ Boys Girls 3/4 5/6 7/8



Tigard Lacrosse Club Medical Release

Directions

Athlete History should be completed by parents prior to the physical. Health Examination must be completed by a licensed physician or nurse practitioner, and be dated after July 1st of the prior year. Return completed Medical Release Forms to: TLC Registrar, 15685 SW 116th Ave. PMB #144, Tigard, OR 97224.

Athlete History (To be filled in by parent or guardian)

1. Has the athlete been hospitalized, had surgery, an injury or serious medical illness in the last five (5) years? If yes, please explain.

2. Is the athlete currently under the care of a physician or taking any medication? If yes, please explain.

3. Has a physician recommended or do you feel there should be limits placed on the athlete's participation in youth sports programs? _____
4. Does the athlete currently need or use an inhaler? _____
5. Does the athlete have any known food or medication allergies? If yes, please list.

6. Has this athlete ever lost consciousness or suffered a blackout during physical activity? If yes, please explain. _____
7. Does this athlete wear eyeglasses or contact lenses? If yes, please provide date of the most recent eye exam. _____

I attest that the above answers are true to the best of my knowledge.

Parent/Guardian Signature

Printed Name

Date

Health Examination (To be filled in by Physician or Nurse Practitioner)

Athlete's Full Name _____
(Last) (First) (Middle Initial)

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Should there be any limitations placed on this athlete for athletic participation? If yes, please list limitations below.

I certify that I have examined this person and that, on the basis of the examination requested by Tigard Lacrosse Club, and the person's medical history, I have found no reason which would make it medically inadvisable for this person to compete in supervised athletic activities. (Note Exceptions above)

Physician's Signature _____ Date _____

Physician's Name _____ Ph. Number _____

Physician's Street Address _____