



## AAU BASKETBALL PHYSICAL FITNESS & MEDICAL RELEASE FORM

**Special Note:** Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, physician assistant, nurse practitioner, etc.) This form must be submitted prior to the athlete participating in AAU. Other physical forms are acceptable.

### Section I

*Legal Name of Participant (must match birth certificate):*

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No \_\_\_\_\_

Name of Primary Medical Insurance Company \_\_\_\_\_

Policy Number: \_\_\_\_\_ Membership Number \_\_\_\_\_

Name on Policy \_\_\_\_\_

### MEDICAL HISTORY

- |   |                    |
|---|--------------------|
| 1. Are there any injuries requiring medical attention?                              | Yes _____ No _____ |
| 2. Are there any past surgeries or scheduled surgeries?                             | Yes _____ No _____ |
| 3. Is the participant currently under the care of a medical practitioner?           | Yes _____ No _____ |
| 4. Is the participant currently taking any medications?                             | Yes _____ No _____ |
| 5. Does the participant have any allergies (penicillin, bee stings, etc)?           | Yes _____ No _____ |
| 6. Does the participant have asthma/require the use of an inhaler?                  | Yes _____ No _____ |
| 7. Is the participant diabetic/require medication for diabetes?                     | Yes _____ No _____ |
| 8. Does the participant currently require medication?                               | Yes _____ No _____ |
| 9. Does/has the participant have/had seizures?                                      | Yes _____ No _____ |
| 10. Does the participant wear glasses or contact lenses?                            | Yes _____ No _____ |
| 11. Does the participant wear a brace or other medical support device?              | Yes _____ No _____ |
| 12. Does the participant have any other physical limitations or medical conditions? | Yes _____ No _____ |

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I hereby understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that it is my responsibility to obtain written permission from my child's physician on official medical stationery in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signed \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship to Participant \_\_\_\_\_ Dated \_\_\_\_\_

## **AAU Section II MEDICAL PROFESSIONAL USE ONLY**

Height \_\_\_\_\_ Weight: \_\_\_\_\_ Eyes \_\_\_\_\_

Ears Mouth Nose & Throat  
Respiratory Cardiovascular Neurological  
Musculoskeletal Dermatological Other

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be involved in participating in an AAU basketball program.

I hereby swear and attest that this individual is physically fit and I have found no medical reason which would prevent this individual from safely participating in AAU activities for the 2016 season.

I am therefore clearing this individual for athletic participation without limitation.

**Please place medical professional stamp here or fill out the following:**

Signed \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

Please indicate medical profession (M.D., D.O. R.N., etc.) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Telephone \_\_\_\_\_

***You may attach a signed PPO, HMO or High School Athletic Association Medical Form in lieu of filling out the above information ONLY IF that form contains all of The information requested above.***

***This form can be modified ONLY to comply with local and/or state laws any Modifications must be communicated to writing AAU.***