

Charleston Miracle League Player Medical History & Physician Clearance Form:

Player's Name: _____ **Date of Birth:** _____

Home Address: _____

Home Phone: _____ **Alternate Phone:** _____

Name of Parent(s)/Gaurdian(s): _____

Medical Diagnosis: _____

Medical Information:

Tetanus Shot: no yes, date of last shot: _____

Seizures: no yes

If yes, are seizures controlled by medication? _____ Date of last seizure: _____

Medications player is currently taking (attach second sheet if necessary):

Please indicate if the player has a problem and/or surgeries in any of the following areas by checking YES or NO. If YES please comment (attach second sheet if necessary):

AREA	NO	YES	COMMENT
Auditory			
Visual			
Speech			
Circulatory/Cardiac			
Pulmonary/respiratory/asthma			
Neurological			
Muscular			
Orthopedic			
Allergies			
Learning Disability			
Mental Impairment			
Psychological Impairment/behavioral			
Other			

Mobility:

Please indicate the player's primary mode for moving in the community:

- walking independently
- walking with help from caregiver
- walking using an assistive device (ie. walker, crutches)
- wheelchair user

Please indicate any other special precautions or equipment used by player when moving in community settings:

Physician Statement – signature required: *Based on my knowledge of this patient, he/she is medically cleared to participate in the Charleston Miracle League.*

Physician's Name (please print): _____

Signature: _____ Date: _____

Address of Physician's office: _____

Phone: _____ Fax: _____ Email: _____

***Please fax form to (843) 763-2514 or mail to P.O. Box 22072, Charleston, SC 29413**