

Adaptive Sports Event Medical Clearance Form

Participant Information

Full Name

Date of Birth

Address

Phone

Email

Emergency Contact

Name

Phone

Relationship

Medical Information

Primary Diagnosis / Disability

Current Medications

Allergies

Relevant Medical History

Event Details

Event Name

Event Date(s)

Sport(s) Participating In

Physician Section

Cleared for full participation?

If Limited, please specify restrictions

Physician Name

Signature

Date