



Pop Warner Little Scholars, Inc.



2008 PHYSICAL FITNESS & MEDICAL HISTORY FORM

NOTE: This form must be dated after January 1, 2008 and then submitted to your LOCAL Pop Warner organization. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc. – this may vary by state). NO other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/or state laws or because of medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to the modified/substituted form.

Section I: FOR PARENT/GUARDIAN COMPLETION ONLY

Legal Name of Participant (must match birth certificate):

Last: _____ First: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell or Work #: _____

Date of Birth: _____ Male Female

Name of Primary Medical Insurance Company: _____

Policy Number: _____ Membership Number: _____

Name on Policy: _____

Sport (check one): Flag Tackle Cheer

PARTICIPANT MEDICAL HISTORY

- | | | |
|---|------------------------------|-----------------------------|
| 1. Are there any injuries requiring medical attention? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are there any past surgeries or scheduled surgeries? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Is the participant currently under the care of a medical practitioner? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Is the participant currently taking any medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does the participant have any allergies (penicillin, bee stings, etc)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Does the participant have asthma/require the use of an inhaler? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Is the participant diabetic/require medication for diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Does the participant currently require medication? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Does/has the participant have/had seizures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Does the participant wear glasses or contact lenses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Does the participant wear a brace or other medical support device? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Does the participant have any other physical limitations or medical conditions? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 certify that this information is accurate to the best of my knowledge. I 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 stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signed _____

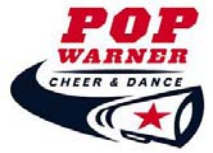
Print Name _____

Relationship to Participant _____

Dated _____



Pop Warner Little Scholars, Inc.



2008 PHYSICAL FITNESS & MEDICAL HISTORY FORM (cont.)

Section II: THIS SECTION IS TO BE COMPLETED ONLY BY A STATE LICENSED MEDICAL PROFESSIONAL

Participant's Name

Last: _____ First: _____ Middle: _____

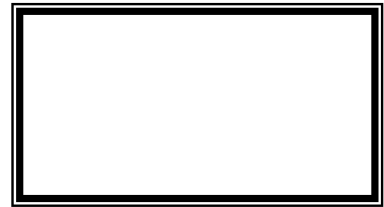
Date of Birth: _____ Sex: Male Female

(Please check the following healthy or note otherwise):

Height	Weight	Eyes
Ears	Mouth	Nose & Throat
Respiratory	Cardiovascular	Neurological
Muskoskeletal	Dermatological	Blood Pressure

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 Pop Warner football, cheer or dance programs. 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 Pop Warner activities for the 2008 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 (MD, DO, RN, etc.): _____

Facility Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____

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NO PHOTOCOPY OF A PHYSICAL WILL BE ACCEPTED IT MUST HAVE AN ORIGINAL SIGNATURE OR STAMP