Pop Warner Little Scholars, Inc.

2020 PHYSICAL FITNESS & MEDICAL HISTORY FORM

Special Note: This form is be dated after January 1, 2020 and then submitted to your LOCAL Pop Warner organization.
No other are acceptable. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.). Section II is modified or substituted ONLY to comply with local and/or state laws or 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 any modified/substituted form.

Section I: FOR PARENT/GUARDIAN COMPLETION ONLY

Legal Name of Participant (must match birth certificate):

Last_____ First_____ Middle_____

Address:_____ City:_____ State:_____ Zip:_____

Telephone No:_____ Date of Birth:_____ Male_____ Female _____

Name of Primary Medical Insurance Company:_____ Policy Number: _____

Membership Number:_____ Name of Primary Insured: _____

Does primary insured have Medicaid? Yes No Does primary insured have Medicare? Yes No

Sport (check one): Cheer____ Dance____ Tackle____ Flag____

PARTICIPANT 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 there any history of concussions and/or head injuries?	Yes	No
4.	Is the participant currently under the care of a medical practitioner?	Yes	No
5.	Is the participant currently taking any medications?	Yes	No
6.	Does the participant have any allergies (penicillin, bee stings, etc)?	Yes	No
7.	Does the participant have asthma/require the use of an inhaler?	Yes	No
8.	Is the participant diabetic/require medication for diabetes?	Yes	No
9.	Does the participant carry sickle cell trait/suffer from sickle cell disease?	Yes	No
10.	Does the participant currently require medication?	Yes	No
11.	Does/has the participant have/had seizures?	Yes	No
12.	Does the participant wear glasses or contact lenses?	Yes	No
13.	Does the participant wear a brace or other medical support device?	Yes	No
14.	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 and/or attach to this form:

_____

_____

_____

If you answered yes about concussions, provide the name of the doctor or qualified medical professional who clearedParticipant for this activity: _____

_____

I certify that this information is accurate. 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. Further, I 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's my responsibility to obtain written permission from my child's physician on official medical stationary in order for my child to resume participation after any and all such injury, illness or accident.

Signature of Parent or Legal Guardian: _____
Print Name_____
Relationship to Participant _____
Dated_____

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Section II: THIS SECTION MUST BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL ON OR AFTER JANUARY 1ST of the CURRENT CALENDAR YEAR.

Name of Participant: _____

(Please check the following if healthy or note otherwise):

Height	Weight	Eyes
Ears	Mouth	Nose & Throat
Respiratory	Cardiovascular	Neurological
Musculoskeletal	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 participating in Pop Warner football, cheer or dance programs. I hereby attest that this individual is physically fit and I have found no medical reason which would prevent this individual from participating in Pop Warner activities for the 2020 season. I am therefore clearing this individual for athletic participation without limitation.

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

Are you licensed in your state to perform physical examinations? YES NO

Today's Date: _____

Please sign and fill out the following information OR place Official Medical Practice Stamp here:

Signature_____Printed Name_____

Address_____City_____State_____Zip_____

Phone_____Fax: _____

Email/Website: Email_____(Optional)

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 any modified/substituted form that MUST be signed in the current calendar year.