



Pop Warner Little Scholars, Inc.

2020 PHYSICAL FITNESS & MEDICAL HISTORY FORM



Special Note: This form is to be dated after January 1, 2020 and then submitted to your LOCAL Pop Warner organization. No other forms 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 _____

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 cleared Participant 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 _____