



PHYSICAL FITNESS & MEDICAL HISTORY FORM

THIS FORM IS VALID FOR 2 YEARS FROM THE DATE OF THE DOCTOR'S SIGNATURE.

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: _____

Also known as: _____ Date of Birth: _____ Gender: M F

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Sport: Football / Cheer

Medical Insurance Company: _____ ID Number: _____

Name of Primary Insured: _____

Does participant have Medicaid? Yes No

Does participant have Medicare? Yes No

Participant Medical History:

1. Does the participant have 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 questions above, please provide the question number and an explanation below or attach to this form:

If you answered Yes about concussions, please provide the name of the doctor or 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 is my responsibility to obtain written permission from my child's physician on official medical stationery in order for my child to resume participation after any and all such injury, illness or accident.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Printed Name: _____ Relationship to athlete: _____

Section II: This section must be completed by a licensed medical professional.

Please check the box next to each option 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 Inland Northwest Youth Football or Cheer League programs. I hereby attest that this individual is physically fit and has no medical condition which would prevent this individual from participating in activities for the current 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 complete the following information or place Official Medical Practice Stamp:

Signature: _____ Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Email/Website: _____

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.