Pop Warner Little Scholars, Inc.

2021 PHYSICAL FITNESS & MEDICAL HISTORY FORM

Special Note: This form is to be dated after January 1, 2021 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 ☐

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 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:

Pop Warner Little Scholars, Inc.

2021 PHYSICAL FITNESS & MEDICAL HISTORY FORM

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 has no medical condition which would prevent this individual from participating in Pop Warner activities for the 2021 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: _____ (Optional)

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