



# SCEYFL-AAU CONFERENCE

AMATEUR ATHLETIC UNION - SOUTHERN CALIFORNIA - SOUTHERN PACIFIC REGION

## PHYSICAL FORM

### SECTION I: CHAPTER INFORMATION | TO BE COMPLETED BY CHAPTER OFFICIALS

CHAPTER \_\_\_\_\_ TEAM CITY \_\_\_\_\_

<b>DIVISION:</b>	6U	8U	10U	12U	13U	14U	CHEERLEADING
------------------	----	----	-----	-----	-----	-----	--------------

### SECTION II: PLAYER INFORMATION | TO BE COMPLETED BY CANDIDATE PLAYER & PARENTS

FIRST NAME	MIDDLE NAME	LAST NAME	AGE OF JULY 31
NAME ON POLICY		PRIMARY MEDICAL INSURANCE COMPANY	POLICY NUMBER

### SECTION III: PARTICIPANT MEDICAL HISTORY | TO BE COMPLETED BY CANDIDATE PLAYER & PARENTS

1. Are there any injuries requiring medical attention?	<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
2. Are there any past surgeries or scheduled surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Does the participant currently require medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the participant currently under medical care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Does/has the participant have/had seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the participant currently taking any medications?	<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
5. Does the participant have any allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Does the participant wear a brace or medical device?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the participant have asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Does the participant have physical limitations/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 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.

PARENT/GUARDIAN	PARENT/GUARDIAN SIGNATURE	DATE
-----------------	---------------------------	------

Printed Name

Signature

Date

RELATIONSHIP TO MINOR: FATHER  MOTHER  LEGAL GUARDIAN

### SECTION IV: MEDICAL EXAMINATION | TO BE COMPLETED ONLY BY A STATE LICENSED MEDICAL PROFESSIONAL

HEIGHT:	WEIGHT:	BLOOD PRESSURE:
---------	---------	-----------------

**DO NOT SIGN OR STAMP DOCUMENT IF CHILD DOES NOT PHYSICALLY QUALIFIED TO PARTICIPATE WITHOUT RESTRICTIONS**

I certify that I have on this date examined this child and that, on the basis of the examination requested and the child's medical history as furnished to me, meet the requirement for participation in this youth football and cheer program.



Examining Dr. \_\_\_\_\_ Office Phone \_\_\_\_\_ Date \_\_\_\_\_