

Pop Warner Little Scholars, Inc.

2016 PHYSICAL FITNESS & MEDICAL HISTORY FORM



Special Note: This form must be dated after January 1, 2016 and then submitted to your LOCAL Pop Warner organization.

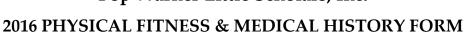
No other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/or state laws or because of medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to any modified/substituted form. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.)

Section I: FOR PARENT/GUARDIAN COMPLETION ONLY

Legal Nan	ne of Participant (must match birth certificate):			
LastMiddle				
Address:_	City:	St	ate:	Zip:
Telephone	No: Date of Birth:		Male	Female
Name of P	rimary Medical Insurance Company:	Policy Number	er:	
Membersh	ip Number: Name of Primary Insured	1:		
Does prim	ary insured have Medicaid? Yes No Does primary in	nsured have Medicare? Yes N	O	
Sport (che	eck one): Cheer Dance Tackle Flag_			
	PANT MEDICAL HISTORY			
1.	Are there any injuries requiring medical attention?	Y	es]	No
2.	Are there any past surgeries or scheduled surgeries?			No
3.	Is there any history of concussions and/or head injuries?	Y		No
4.	Is the participant currently under the care of a medical p		es l	No
5.	Is the participant currently taking any medications?			No
6.	Does the participant have any allergies (penicillin, bee s			No
7.	Does the participant have asthma/require the use of an in			No
8.	Is the participant diabetic/require medication for diabete		es l	No
9.	Does the participant carry sickle cell trait/suffer from sic			No
10.	Does the participant currently require medication?		es l	No
11.	Does/has the participant have/had seizures?	Y	es l	No
12.	Does the participant wear glasses or contact lenses?	Y	es l	No
13.	Does the participant wear a brace or other medical supp	ort device? Y	es l	No
14.	Does the participant have any other physical limitations		es l	No
	wered yes to any of the above questions, please provide the ach to this form:			
may be vo Furtherm writing if written po	certify that this information is accurate to the best of my olded in the event of injury, illness or accident and my clore, I hereby acknowledge that it is my responsibility to there is any change in the medical condition of my child ermission from my child's physician on official medical articipation after any and all such injury, illness or accident	hild may not be cleared for pa o inform my child's coach or o l. I also understand that it's n stationary in order to seek pe	rticipa rganiza y respo	tion at such time. ation official in onsibility to obtain
Signature	of Parent or Legal Guardian:			
Print Nam	e			
Relationsh	ip to Participant			
Dated				
1/20/201	6 PWLS, INC.			



Pop Warner Little Scholars, Inc.





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 heal	thy or note otherwise):			
Height	Weight	Еу	yes	
Ears	Mouth	No	ose & Throat	
Respiratory	Cardiovascular	Ne	eurological	
Muskoskeletal	Dermatological	Bl	lood Pressure	
I hereby certify that I am a and understand that he/she programs. I hereby swear reason which would prevent 2016 season. I am therefore	e will be involved in partic and attest that this individ at this individual from safe	ipating in Po dual is physic ely participa	op Warner footb cally fit and I hav ting in Pop Warn	all, cheer or dance ve found no medical ner activities for the
Please indicate medical profession				
Are you licensed in your state to pe	erform physical examinations?	YES NO	O	
Dated:				
Please sign and fill out the	following information OR	place Officia	al Medical Pract	ice Stamp here:
Signature		Printed Name_		
Address	City		State	Zip
Phone	Fax:		_	

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.

(Optional)

Email/Website: Email_