



Pop Warner Little Scholars, Inc.



2006 PHYSICAL FITNESS & MEDICAL HISTORY FORM

Special Note: This form must be dated after January 1, 2006 and is applicable only for the 2006 season. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, physician assistant, nurse practitioner, etc.).

This form must be submitted to your LOCAL Pop Warner organization prior to the athlete participating in Pop Warner. No other forms are acceptable.

(This Form is Under Discussion at the Regional Meetings and is NOT Mandatory.)

Section I

Legal Name of Participant (must match birth certificate):

Last _____ First _____ Middle _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No: _____

Name of Primary Medical Insurance Company: _____

Policy Number: _____ Membership Number: _____

Name on Policy _____

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 the participant currently under the care of a medical practitioner? | Yes | No |
| 4. | Is the participant currently taking any medications? | Yes | No |
| 5. | Does the participant have any allergies (penicillin, bee stings, etc)? | Yes | No |
| 6. | Does the participant have asthma/require the use of an inhaler? | Yes | No |
| 7. | Is the participant diabetic/require medication for diabetes? | Yes | No |
| 8. | Does the participant currently require medication | | |
| 9. | Does/has the participant have/had seizures? | Yes | No |
| 10. | Does the participant wear glasses or contact lenses? | Yes | No |
| 11. | Does the participant wear a brace or other medical support device? | Yes | No |
| 12. | 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:

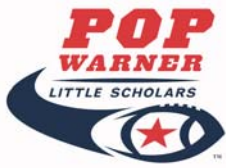
I hereby understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if 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.

Signed _____

Print Name _____

Relationship to Participant _____

Dated _____



Pop Warner Little Scholars, Inc.



Section II MEDICAL PROFESSIONAL USE ONLY

Height	Weight	Eyes
Ears	Mouth	Nose & Throat
Respiratory	Cardiovascular	Neurological
Muskoskeletal	Dermatological	Other

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be involved in participating in Pop Warner football, cheer or dance programs. I hereby swear and attest that this individual is physically fit and I have found no medical reason which would prevent this individual from safely participating in Pop Warner activities for the 2006 season. I am therefore clearing this individual for athletic participation without limitation.

Please place medical professional stamp here or fill out the following:

Signed _____ Date: _____

Print Name _____

Please indicate medical profession (M.D., D.O. R.N., etc.) _____

Address _____ City _____ State _____

Telephone _____

You may attach a signed PPO, HMO or High School Athletic Association Medical Form in lieu of filling out the above information ONLY IF that form contains all of the information requested above.

This form can be modified ONLY to comply with local and/or state laws Any modifications must be communicated to writing to Pop Warner Little Scholars, Inc.