PHYSICAL FITNESS AND MEDICAL HISTORY FORM (1 of 2)

This form must be dated after 1/1/2019 and then submitted to your CLUB within FYFCL, a member of AAU.

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 the 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 Name of Participant (must match birth certificate):

Last _________________________________ First_______________________ Middle___________________

Address:____ City:_____________________________ State: FL Zip:__________

Telephone No:___________________________ Date of Birth ____/ ____/ ________ Male____ Female ____

Name of Primary Medical Insurance Company:_______________________________ Policy Number: _________________________

Membership Number:_________________ Name of Primary Insured: ____

Sport (check one): Cheer_____ Dance_____ Tackle______ Flag_____

PARTICIPANT MEDICAL HISTORY (check one)

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? Yes_____ No_____
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 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 it's 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.

Signature of Parent or Legal Guardian: ____

Print Name: ____

Relationship to Participant: ____

Dated: ____/ ____/ ________

PHYSICAL FITNESS AND MEDICAL HISTORY FORM (2 of 2)

Section II: THIS SECTION IS TO BE COMPLETED ONLY BY A MEDICAL PROFESSIONAL

Legal Name of Participant:

Last _________________________________ First_______________________ Middle___________________

(Please check the following if healthy or note otherwise):
Height: _____________ | Weight: _____________ | Eyes: _____________
notes:____
Ears: _____________ | Mouth: _____________ | Nose & Throat: _____________
notes:____
Respiratory: _____________ | Cardiovascular: _____________ | Neurological: _____________
note:____
Muskoskeletal: _____________ | Dermatological: _____________ | Blood Pressure: _____________
notes:____

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 AAU football or cheer 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 Florida Youth Football and Cheer League activities for the 2018 season. I am therefore clearing this individual for athletic participation without limitation.

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

Signed____
Dated: ____/ ____/ ________
Print Name____

Please indicate medical profession (M.D., D.O. R.N., etc.)________________
Complete this section or the medical professional's stamp may be placed below.
Address____City_________________________________State_________
Telephone ______________________________ Fax Number: ______________________

Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc. 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 the modified/substituted form.