



PHYSICAL FITNESS AND MEDICAL HISTORY FORM (1 of 2)

This form must be dated after 1/1/2017 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 2017 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: _____

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