CENTRAL RAZORBACKS PHYSICAL FITNESS & MEDICAL HISTORY

<u>Special Note:</u> This form must be dated and then submitted to your organization each season.
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: _____
Telephone No:_____ Date of Birth: _____/_____/_____ (Please check) Male____
Female ____ Month/ Day / Year
Name of Primary Medical Insurance Company: _____
Policy Number: _____Membership Number: _____
Name of Primary Insured: _____
Sport (check one): Cheer_____ Dance_____ Tackle_____ Flag_____

PARTICIPANT 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? 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/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.

_____.
Parent or Legal Guardian **(Print)**

_____.
Parent or Legal Guardian **(Signature)**

Relation to Participant: _____.

Dated: _____.

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

Name of Participant: _____

(Please **check the following if healthy** or note otherwise):

Height _____Weight _____Eyes _____
Ears _____Mouth _____ Nose _____ Throat _____
Respiratory _____ Cardiovascular _____ Neurological _____
Muscle-skeletal _____ Dermatological _____ Blood Pressure _____

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 football programs. I hereby swear and attest that this individual is physically fit and I have found no medical conditions that would prevent this individual from safely participating in football activities for the upcoming season. I am therefore clearing this individual for athletic participation without limitation.

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

Date: _____.
Print Name: _____
Please indicate medical profession (M.D., D.O. R.N., etc.):_____
Address: _____ City: _____ State: _____
Telephone: _____
Fax Number: _____

ONLY a Licensed State Examiner must complete section II in its entirety (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 the modified/substituted form.

Medical Stamp Here

Signature of Medical Physician _____ **DATE:**_____