PHYSICAL FITNESS & MEDICAL HISTORY FORM

Special Note: This form must be dated within 60 days of the start of the season or program.
Section II must be completed ONLY by a Licensed State Examiner (medical doctor, nurse practitioner)

Section I: FOR PARENT/GUARDIAN COMPLETION ONLY

Name of Participant (must match birth certificate):
Last ________________________________ First______________________ Middle______________
Date of Birth: __________________________ Male____ Female ____
Address:_____________________________________ City:__________________ State: __________
Zip:__________ Telephone No:__________________________

Primary Medical Insurance:___________________________ Policy Number: _____________________
Membership Number:________________ Name of Primary Insured: ____________________________

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 there any history of concussions and/or head injuries? □Yes □No
4. Is the participant currently under the care of a medical practitioner? □Yes □No
5. Is the participant currently taking any medications? □Yes □No
6. Does the participant have any allergies (penicillin, bee stings, etc)? □Yes □No
7. Does the participant have asthma/require the use of an inhaler? □Yes □No
8. Is the participant diabetic/require medication for diabetes? □Yes □No
9. Does the participant carry sickle cell trait/suffer from sickle cell disease? □Yes □No
10. Does the participant currently require medication? □Yes □No
11. Does/has the participant have/had seizures? □Yes □No
12. Does the participant wear glasses or contact lenses? □Yes □No
13. Does the participant wear a brace or other medical support device? □Yes □No
14. 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 and/or attach to this form:
____
____
____

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______________________

New England Youth Tackle Football Inc. 679 Western ave. Suite 2, Lynn MA 01905
508-NEYTFL9 (508-639-8359) | Neytfootball@gmail.com | www.neytfootball.org

SECTION II: LICENSED EXAMINER ONLY (MEDICAL DOCTOR, NURSE PRACTITIONER)

Participant:____

(Please check the following if healthy or note otherwise): ✓ Healthy -- _X_ Not Healthy

☐Height ☐Weight ☐Eyes ☐Ears ☐Mouth

☐Nose & Throat ☐Respiratory ☐Cardiovascular ☐Neurological

☐Musculoskeletal ☐Dermatological ☐Blood Pressure

Date Last Physical Exam: ____________________ Next Scheduled Physical Exam ___________________

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 NEYT's Youth Football program. 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 youth tackle football. I am therefore clearing this individual for athletic participation without limitation.

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

Are you licensed in your state to perform physical examinations? ☐YES / ☐NO

Please sign and fill out the following information OR place Official Medical Practice Stamp here:
Signature____, Date: __________________________
Printed Name______________________________________

Practice Name:____
Address____City______________________State_____
Zip__________ Phone _____________________________________ Fax: _______________________
Website:___________________________________, Email____

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.

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