Mechanicsville Braves Youth Football and Cheer Club, Inc

Physical Fitness Form

Physical form must be dated after January 1, 2026 Section I must be completed entirely and submitted with page 2.

SECTION I: COMPLETED BY PARENT OR GUARDIAN

Legal Name of Participant (must match birth certificate):

Last_____First_____Middle_____

Date of Birth: _____ Male __ Female __

Address: _____City: _____ State: ____ Zip: _____

Telephone #: _____

Primary Medical Insurance Company:_____ Policy Number: _____ Membership Number:_____ Name of Primary Insured: _____

Athletic Event (check all that apply): Flag ☐ Tackle ☐ Cheer ☐

PARTICIPANT MEDICAL HISTORY

Are there any injuries requiring medical review? Yes ☐ No ☐
Are there any past surgeries or scheduled surgeries? Yes ☐ No ☐
Is the participant currently under the care of a medical professional? Yes ☐ No ☐
Does/has the participant have/had seizures? Yes ☐ No ☐
Does the participant currently require medication? Yes ☐ No ☐
Does the participant wear glasses or contact lenses? Yes ☐ No ☐
Does the participant wear a brace or other medical support items? Yes ☐ No ☐
Does the participant have any allergies (penicillin, bee stings, etc)? Yes ☐ No ☐
Does the participant have any other physical limitations or medical concerns/conditions? Yes ☐ No ☐
Does the participant have asthma/require the use of an inhaler? Yes ☐ No ☐
Is the participant diabetic/require medication for diabetes? Yes ☐ No ☐
Is the participant currently taking any medications? Yes ☐ No ☐
If you answered yes to any of the above questions, please provide an explanation below:

_____

_____

_____

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. 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 doctor (on 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: _____ Date: _____

Print Name_____

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SECTION II: COMPLETED ONLY BY PARTICIPANT'S DOCTOR

Name of Participant: _____

Please check the following if healthy or note otherwise:

Height ☐ Weight ☐ Eyes ☐ Ears ☐ Mouth ☐ Respiratory (Nose/Throat) ☐ Neurological ☐
Dermatological ☐ Blood Pressure ☐ Cardiovascular ☐

I hereby certify that I am a licensed state examiner and have examined the participant identified above. I understand that he/she will be participating in one/up to three of the following sporting events: Tackle Football, Flag Football, or Cheerleading. I am clearing this individual for athletic participation without limitation.

Comments or Concerns:

_____
_____
_____
_____

Please place medical professional stamp here or fill out the information below:

Signed_____ Date: _____

Print Name_____

Please indicate medical profession _____

Please complete this section if the medical stamp does not include the information 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). 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.