Flour Bluff Youth Sports

2017 PHYSICAL FITNESS & MEDICAL HISTORY FORM

This form must be submitted to FBYS –prior to athlete participation.

Legal name of Participant (must match birth certificate)

Last: _____ First: _____ Middle: _____

Address: _____

City: _____State: _____ Zip: _____

Telephone number: _____

Name of primary Medical Insurance Company: _____

Policy Number: _____Membership Number: _____

Name of Policy: _____

1. Are there any injuries requiring medical attention? Yes No
2. Are there any past surgeries? Yes No
3. Is the participant currently under any medical care? Yes No
4. Does the participant have any allergies? Yes No
5. Does the participant have asthma / require use of inhaler? Yes No
6. Is the participant a diabetic / require medications? Yes No
7. Does the participant or has he / she had seizures? Yes No
8. Does the Participant have any other limitations or Medical conditions? Yes No

If you answered Yes to any of the above questions above please provide an explanation in the following space:

_____
_____
_____

I hereby acknowledge that it is my responsibility to inform my child's coach in writing if there is any change in his / her medical condition. I also understand that it is 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.

Signed: _____

Print Name: _____

Relationship to participant: _____ Date: _____

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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
Musculoskeletal	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 FBYS. 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 FBYS 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_____

Date:_____

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. – 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.