Rock City Trojans Youth Football and Cheer League

PHYSICAL FITNESS & MEDICAL HISTORY FORM

This form must be dated after January 1, 2023 and submitted to your CLUB within CVC, a member of AAU.

Section I must still be filled out entirely. 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: ____ Zip:_____

Telephone No:_____ Date of Birth: _____Male____ Female ____

Name of Primary Insured: _____

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

Sport (check one): Cheer_____ 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 or medical conditions? Yes /No

If you answered yes to any questions, 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 _____

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***	***Blood Pressure***
Eyes	***Mouth***	***Ears***
Nose & Throat	***Respiratory***	***Cardiovascular***
Neurological	***Muskoskeletal***	***Dermatological***

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 2020 season. I am therefore clearing this individual for athletic participation without limitation.

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

Stamp Here

Signed_____ b

Date:_____

Print Name_____

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

Address_____

City_____ State_____

Telephone _____ /Fax Number: _____