PALISADES YOUTH FOOTBALL ASSOCIATION
P.O. BOX 82
KINTNERSVILLE, PA 18930

2020 PHYSICAL FITNESS AND MEDICAL HISTORY FORM

Special Note: This form must be dated after January 1, 2020 and then submitted to Palisades Youth Football and Cheerleading Association. 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. 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:

Home #: Cell #:

Date of Birth: (MM/DD/YYYY) Male ☐ Female ☐ (Check One)

Name of Primary Medical Insurance Company: ID #: Group #:

Name of Primary Insured:

Sport (Check One) Tackle ☐ Flag ☐ Cheer ☐

	PARTICIPANT MEDICAL HISTORY - Check Yes or No	Yes	No
1.	Are there any injuries requiring medical attention?		
2.	Are there any past surgeries or scheduled surgeries?		
3.	Is the participant currently under the care of a medical practitioner		
4.	Is the participant currently taking any medications?		
5.	Does the participant have any allergies (penicillin, bee stings, etc)?		
6.	Does the participant have asthma/require the use of an inhaler?		
7.	Is the participant diabetic/require medication for diabetes?		
8.	Does the participant currently require medication?		
9.	Does/has the participant have/had seizures?		
10.	Does the participant wear glasses or contact lenses?		
11.	Does the participant wear a brace or other medical support device?		
12.	Does the participant have any other physical limitations or medical conditions?		

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.

Signature of Parent or Legal Guardian:

Print Name: Date:

Relationship to Participant:

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Physical Form - Palisades Youth Football and Cheerleading Association
This form must be dated after January 1, 2020.

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

Name of Participant: D.O.B.:

Height:	Weight:	Pulse:	Blood Pressure:

Vision: Corrected R / Uncorrected R / Corrected L / Uncorrected L /

	Check Normal or Abnormal	Normal	Abnormal
1.	Eyes		
2.	Ear, Nose, and Throat		
3.	Mouth and Teeth		
4.	Neck		
5.	Cardiovascular		
6.	Chest and Lungs		
7.	Abdomen		
8.	Skin		
9.	Genitalia-Hernia (male)		
10.	Musculoskeletal: ROM, strength, etc		
a.	Neck		
b.	Spine		
c.	Shoulders		
d.	Arms/Hands		
e.	Hips		
f.	Thighs		
g.	Knees		
h.	Ankles		
i.	Feet		
11.	Neuromuscular		

Participation Restrictions:

Please Print/ Stamp

Physician's Name

Street Address

City, State, Zip Code

Telephone

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 Palisades Youth Football and/or Cheer or dance 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 Palisades Youth Football and/or Cheer or dance programs for the 2020 season. I am therefore clearing this individual for athletic participation without limitation.

Please place medical professional stamp here or complete signature and date.

Physician Signature _____ Date _____