Medical and Fitness Form:

Special Note: This form must be dated after January 1, 2017.
Section I must 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: ______ Zipcode:_____________

Phone:____________________________

Date of Birth: ____________________________ Male____ Female ____

Primary Medical Insurance Company:_______________________________

Policy Number: _______________________

Membership Number:__________________

Name of Primary Insured:____

Does primary insured have Medicaid? Yes No

Does primary insured have Medicare? Yes No

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 currently require medication? Yes No

10. Does/has the participant have/had seizures? Yes No

11. Does the participant wear glasses or contact lenses? Yes No

12. Does the participant wear a brace or other medical support device? Yes No

13. 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 or attach:
____

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_____________ Date: ___________________________

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Section II: THIS SECTION MUST BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL

Name of Participant:____

(Please check the following if healthy or note otherwise):

Height______ Weight_____ Eyes____
Ears ____Mouth____

Nose & Throat
______Respiratory____ Cardiovascular_____

Neurological_____ Muskoskeletal ____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 Princeton Junior Football League (PJFL) Flag 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 PJFL 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 that MUST be signed in the current calendar year.