# SOUTH FLORIDA NATIONAL YOUTH FOOTBALL LEAGUE
## 2023 PHYSICAL FITNESS & MEDICAL HISTORY FORM

**Special Note: This form must be dated after January 1, 2022 and then submitted to your SFNYFL organization.**

**No other forms are acceptable or substituted ONLY to comply with SFNYFL 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:_____**

**Telephone No:_____ Date of Birth: _____ Male_____ Female _____**

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

**Membership Number:_____ Name of Primary Insured: _____**

**Sport (check one): Cheer_____ Dance_____ Tackle_____ Flag_____**

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**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 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_____**

**Relationship to Participant_____Dated_____**

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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** |
| **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 SFNYFL football, 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 SFNYFL activities for the 2022 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.**