

Name of Participant:

## Pop Warner Little Scholars, Inc. PHYSICAL FITNESS & MEDICAL HISTORY FORM



## Section II: THIS SECTION MUST BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL ON OR AFTER JANUARY $1^{\underline{ST}}$ of the CURRENT CALENDAR YEAR.

This form 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).

(Please check the following if hea	lthy or note otherwise):	<del></del>			
Height	Weight		Eyes		
Ears	Mouth		Nose & Throat		
Respiratory	Cardiovascular		Neurological		
Musculoskeletal	Dermatological		Blood Pressure		
I hereby certify that I am a understand that he/she wil attest that this individual is from participating in Pop athletic participation with	l be participating in s physically fit and h Warner activities for	Pop Warner footbass no medical cond	all, cheer or dan lition which wo	ice programs. I hereby uld prevent this individ	
Please indicate medical profession	ı (M.D., D.O., R.N., etc.)				
Are you licensed in your state to p	perform physical examina	tions? YES   NO	D 🗆		
Today's Date:					
Please sign and fill out the	J	•	al Medical Pract	tice Stamp here:	
Signature					
Printed Name					
Address	(	City	State	Zip	
Phone	Fax:		_		
Email/Website: Email		(Optional)			

Note to Pop Warner participants: If you're uploading this signed document directly into your participant profile within the Sports Connect roster system, please make sure each page includes a proper signature. It will not be accepted without signatures. Documents can be scanned as PDF files from your smartphone or tablet. CLICK HERE to learn how.