

FLORIDA YOUTH FOOTBALL AND CHEERLEADING ASSOCIATION (FYFCA)

STUDENT ATHLETE PHYSICAL WELLNESS AND EVALUATION FORM

DATE OF PHYSICAL _____

Name as on Birth Certificate	Organization	Age
Street Address	Home Phone	Date of Birth
City/Zip	Cell Phone	Email Address
Sex M F	School	Grade

Mother's Information:

First Name _____ Last Name _____
 Occupation _____ Employer _____
 Cell Phone _____ Work Phone _____
 Email Address _____

Father's Information:

First Name _____ Last Name _____
 Occupation _____ Employer _____
 Cell Phone _____ Work Phone _____
 Email Address _____

Or

Guardian's Information:

First Name _____ Last Name _____
 Occupation _____ Employer _____
 Cell Phone _____ Work Phone _____
 Email Address _____

Emergency Contact

Name _____ Phone _____
 Address _____

Primary Insurance Coverage

Is the student athlete covered by a family medical/hospital insurance? Yes No
 If so, indicate carrier _____ Group # _____ Member # _____
 Phone Number of Carrier _____
 Name plan is under _____
 Name of family physician _____ Phone _____
 Name of family dentist/orthodontist _____ Phone _____

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HEALTH HISTORY

1. STUDENT/ATHLETE INFORMATION:

Name: _____ Sex: ___ Age: ___ DOB: ___/___/___
 Home Address: _____ Phone # () _____
 Name Parent/Guardian: _____ Relationship to S/A _____
 Home Phone () _____ Cell () _____
 Family Physician: _____ City/State _____ Office Ph: () _____

2. MEDICAL HISTORY: The following information must be filled in by the parent/guardian. Keep a copy of the completed form for your records. Any changes to this form should be provided to FYFCA immediately. Provide complete information and explain all YES answers below. CIRCLE questions you do not know answers to.

	Yes	No			Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	30.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you think you are in good health?	<input type="checkbox"/>	<input type="checkbox"/>	31.	Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out DURING exercises?	<input type="checkbox"/>	<input type="checkbox"/>	32.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever passed out or nearly passes out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	33.	Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	34.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	35.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever told you that you have (check all that apply) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High Cholesterol <input type="checkbox"/> A heart infection	<input type="checkbox"/>	<input type="checkbox"/>	36.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	38.	When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	44.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you had any broken or fractured bones or dislocated joints. If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	45.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Chest <input type="checkbox"/> Thigh <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Shoulder <input type="checkbox"/> Foot <input type="checkbox"/> Neck <input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	46.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	47.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you been told that you have or had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY			
23. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	48.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
24. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	49.	How old were you when you had your first menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	50.	How many periods have you had in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
26. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>				

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Explain YES answers here:

ALLERGIES

Medical

Food

Other (include insect stings, hay fever, asthma, animal dander, etc.)

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

RESTRICTIONS

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

PARENT/GUARDIAN CONSENT AND AUTHORIZATION

This health history is correct and complete as far as I know. The student athlete herein described has permission to engage in all activities except as noted. I agree to have my child examined by a licensed physician prior to my child's participation as a member of FYFCA. In the case of an emergency, I understand that every effort will be made to contact the Parent/Guardians of student athletes. If this is not possible, I hereby authorize FYFCA to obtain medical treatment for my child, including without limitation, transportation of my child via ambulance to the nearest hospital.

I understand that FYFCA assumes no responsibility for injuries or illnesses which my child may sustain as a result of his/her physical condition or resulting from his/her participation in any athletic activities, sports programs, the use of any equipment, exercise or other activities.

I authorize FYFCA to remove my child from FYFCA functions in the event FYFCA determines, in its reasonable discretion, that my child's actions are detrimental to the general welfare of FYFCA's functions, program, and other student athletes.

I acknowledge receipt of the recent amendments to the FYFCA's Football and/or Cheerleading Rules, attached hereto. I have read the FYFCA's Football and/or Cheerleading Rules and the amendments thereto. I understand and agree to abide by the policies stated in the Rules, as amended.

Dated: _____

Printed Name of Parent/Guardian

Signature of Parent/Guardian

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PHYSICAL EXAMINATION FORM

The section below is to be completed by physician after Health History and Parental/Guardian consent forms are completed.

Student Athlete NAME _____ DOB ____/____/____

Height _____ Weight _____ Pulse _____ Blood Pressure ____/____ (____/____ - ____/____)

Visual Acuity: Right 20/____ Left 20/____ Corrected: Yes No Pupils: Equal ____ Unequal ____

Medical	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitalia (Male only)			
Skin			

Musculoskeletal	Normal	Abnormal Findings	Initials
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

ASSESSMENT OF EXAMINING PHYSICIAN

I hereby certify that (insert student athlete name) _____ is

- Cleared without restriction
- Cleared with the following limitations

Cleared with recommendations for further evaluation or treatment for:

Not cleared for All Sports Certain Sports: _____

Reason: _____
Recommendations: _____

(insert student athlete name) _____ is being referred to another physician or specialist for further review. Referred to _____ For _____

PHYSICIAN Name (Print) _____ Date _____

ADDRESS: _____

SIGNATURE OF PHYSICIAN _____

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ASSESSMENT OF REFERRED PHYSICIAN

I hereby certify that (insert student athlete name) _____ is

- Cleared without restriction
 Cleared with the following limitations _____

Cleared with recommendations for further evaluation or treatment for:

Not cleared for All Sports Certain Sports: _____

Reason: _____

Recommendations: _____

(insert student athlete name) _____ is being referred to another physician or specialist for further review. Referred to _____ For _____

PHYSICIAN Name (Print) _____ Date _____

ADDRESS: _____

SIGNATURE OF PHYSICIAN _____

TO BE COMPLETED BY PARENT/GUARDIAN

I have reviewed this form in its entirety and completely understand the results and recommendations of the physician performing the examination. I understand this form must be completed in entirety to be considered valid and in order for _____ (name of Student Athlete) to participate as member of a FYFCA Youth Football or Cheerleading organization.

PRINTED NAME OF PARENT/GUARDIAN _____

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____

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WAIVER AND RELEASE OF LIABILITY

In consideration of being permitted to utilize the facilities, services and programs of the FYFCA (or for my children to so participate) for any purpose, including, but not limited to observation or use of facilities or equipment, or participation in any off-site program affiliated with the FYFCA, the undersigned, for himself or herself and such participating children and any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has, or immediately upon entering or participating will, inspect and carefully consider such premises and facilities or the affiliated program. It is further warranted that such entry into the FYFCA for observation or use of any facilities or equipment or participation in such affiliated program constitutes an acknowledgment that such premises and all facilities and equipment thereon and such affiliated program have been inspected and carefully considered and that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use or participation by the undersigned and such children.

In further consideration of being permitted to enter the FYFCA for any purpose including, but not limited to observation or use of facilities or equipment, or participation in any off-site program affiliated with the FYFCA, the undersigned hereby agrees to the following:

1. THE UNDERSIGNED ON HIS OR HER BEHALF AND BEHALF OF SUCH CHILDREN, HEREBY RELEASES, WAIVES, DISCHARGES AND CONVENTS NOT TO SUE FYFCA and all branches thereof, its directors, officers, employees, and agents (hereinafter referred to as "releasees") from all liability to the undersigned or such children and all his personal representatives, assigns, heirs, and next of kin for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned or such children whether caused by the negligence of the releasees or otherwise while the undersigned or such children is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with FYFCA.

2. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releasees and each of them from any, loss, liability, damage or cost they may incur due to the presence of the undersigned or such children in, upon, or about FYFCA premises or in any way observing or using any facilities or equipment of FYFCA or participating in any program affiliated with FYFCA whether caused by the negligence of the releasees or otherwise.

3. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH, OR PROPERTY DAMAGE to the undersigned or such children due to the negligence of releasees or otherwise while in, about or upon the premises of FYFCA and/or while using the premises or any facilities or equipment thereon or participating in any program affiliated with FYFCA.

Dated: _____

Printed Name of Parent/Guardian

Signature of Parent/Guardian

STATE OF FLORIDA
COUNTY OF _____

SWORN TO AND SUBSCRIBED before me on this the ___ day of _____ 2006, by _____, who is either personally known to me or provided _____ as identification and who did take an oath.

Notary Public