

The Fayetteville Browns  
Youth Football and Cheer

**MEDICAL FORM**

**MUST BE COMPLETED BY PHYSICIAN BEFORE YOUR  
CHILD MAY PARTICIPATE IN PRACTICES OR GAMES**

**Child's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Parent or Legal Guardian:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Emergency Contact Phone:** \_\_\_\_\_  
(if parents or guardian are unavailable)

**HOSPITAL TREATMENT AUTHORIZATION**

**I, the undersigned, being the parent or legal guardian, hereby designate the Fayetteville Browns \_\_\_\_\_, coaches and/or designee, to authorize any necessary medical and/or surgical treatment needed for the above named child in my absence.**

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

**THIS MUST BE SIGNED FOR YOUR CHILD TO PARTICIPATE**

## Preparticipation Physical Evaluation

**Physical Examination:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (Optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ (\_\_\_\_ / \_\_\_\_\_, \_\_\_\_ / \_\_\_\_\_)

Vision R20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

**CLEARANCE**

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of physician \_\_\_\_\_  
 (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

**MEDICAL FORM**

**MUST BE COMPLETED BY PHYSICIAN BEFORE YOUR CHILD MAY PARTICIPATE IN PRACTICES OR GAMES**

**Child's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Parent or Legal Guardian:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Emergency Contact Phone:** \_\_\_\_\_  
(if parents or guardian are unavailable)

**HOSPITAL TREATMENT AUTHORIZATION**

**I, the undersigned, being the parent or legal guardian, hereby designate the Fayetteville Browns \_\_\_\_\_, coaches and/or designee, to authorize any necessary medical and/or surgical treatment needed for the above named child in my absence.**

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

**THIS MUST BE SIGNED FOR YOUR CHILD TO PARTICIPATE**

## Preparticipation Physical Evaluation

**Physical Examination:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body fat (Optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ (\_\_\_\_ / \_\_\_\_\_, \_\_\_\_ / \_\_\_\_\_)

Vision R20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

**CLEARANCE**

\_\_\_ Cleared

\_\_\_ Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_ Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_

Name of physician  
 (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

## Preparticipation Physical Evaluation

### HISTORY

### DATE of EXAM \_\_\_\_\_

Name _____	Sex _____	Age _____	Date of birth _____
Grade _____	School _____	Sport(s) _____	
Address _____		Phone _____	
Personal Physician _____			
<b>In case of emergency, contact:</b>			
Name _____	Relationship _____	Phone (H) _____	(W) _____

Explain "Yes" answers below Circle questions you don't know the answers to.	Yes	No		Yes	No
1. Have you had a medical illness or injury since your last sports physical? Do you have an ongoing or chronic illness?	-	-	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	-	-
2. Have you ever been hospitalized overnight? Have you ever had surgery?	-	-		11. Have you had any problems with your eyes or vision? Do you wear glasses, contacts, or protective eyewear?	-
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	-	-	12. Have you ever had a sprain, strain or swelling after injury? Have you broken or fractured any bones or dislocated any joints? Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? If yes, check appropriate box & explain below: _ Head            _ Elbow        _ Hip _ Neck            _ Forearm    _ Thigh _ Back            _ Wrist        _ Knee _ Chest            _ Hand        _ Shin/calf _ Shoulder        _ Finger      _ Ankle _ Upper arm      _ Foot		-
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)? Have you ever had a rash or hives develop during or after exercise?	-	-		13. Do you want to weigh more or less than you do now? Do you lose weight regularly to meet weight requirements for your sport?	-
5. Have you ever passed out during or after exercise? Have you ever been dizzy during or after exercise? Have you ever had chest pain during or after exercise? Do you get tired more quickly than your friends do during exercise? Have you ever had racing of your heart or skipped heartbeats? Have you had high blood pressure or high cholesterol? Have you ever been told you have a heart murmur? Has any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?	-	-	14. Do you feel stressed out? 15. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____		-
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory? Have you ever had a seizure? Do you have frequent or severe headaches? Have you ever had numbness or tingling in your arms, hands, legs, or feet? Have you ever had a stinger, burner, or pinched nerve?	-	-		<b>FEMALES ONLY</b>	
7. Have you ever become ill from exercising in the heat?	-	-	16. When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____	-	-
8. Do you cough, wheeze, or have trouble breathing during or after activity? Do you have asthma? Do you have seasonal allergies that require medical treatment?	-	-		Explain "Yes" answers here: _____ _____ _____ _____ _____ _____	

**Athletes Name:**

**Date:**

**Parent/Guardian's Name:**

**Parent/Guardian's Home Address:**

**MEDICAL HISTORY**

**List all medications you take and the reason you take them:**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

**List any drugs, food or airborne allergies you have:**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

**List any Surgeries or Hospitalizations you have had:**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

**List whether you wear corrective lenses, contacts, braces, retainers or other appliances:**

- 1.
- 2.
- 3.
- 4.