

# SCEYFL-AAU CONFERENCE

Amateur Athletic Union – California AAU - Southern Pacific Region



## PHYSICAL FORM

### SECTION I: CHAPTER INFORMATION | TO BE COMPLETED BY CHAPTER OFFICIALS

CHAPTER \_\_\_\_\_ TEAM CITY \_\_\_\_\_

DIVISION:	6U	8U	10U	12U	14U	CHEERLEADING
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### SECTION II: PLAYER INFORMATION | TO BE COMPLETED BY CANDIDATE PLAYER & PARENTS

FIRST NAME	MIDDLE NAME	LAST NAME	AGE OF JULY 31
NAME ON POLICY		PRIMARY MEDICAL INSURANCE COMPANY	POLICY NUMBER

### SECTION III: PARTICIPANT MEDICAL HISTORY | TO BE COMPLETED BY CANDIDATE PLAYER & PARENTS

- |  |                    |   |         |
|--|--------------------|---|---------|
| 1. Are there any injuries requiring medical attention?                 | Yes / No           | 7. Is the participant diabetic/require medication for diabetes? | Yes/ No |
| 2. Are there any past surgeries or scheduled surgeries?                | Yes/ No            | 8. Does the participant currently require medication?           | Yes/ No |
| 3. Is the participant currently under medical care?                    | Yes/ No            | 9. Does/has the participant have/had seizures?                  | Yes/ No |
| 4. Is the participant currently taking any medications?                | Yes/ No            | 10. Does the participant wear glasses or contact lenses?        | Yes/ No |
| 5. Does the participant have any allergies?                            | Yes/ No            | 11. Does the participant wear a brace or medical device?        | Yes /No |
| 6. Does the participant have asthma?<br>require the use of an inhaler? | Yes/ No<br>Yes/ No | 12. Does the participant have physical limitations/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 is 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.

PARENT/GUARDIAN	PARENT/GUARDIAN SIGNATURE	DATE
Printed Name	Signature	Date

RELATIONSHIP TO MINOR: FATHER  MOTHER  LEGAL GUARDIAN

### SECTION IV: MEDICAL EXAMINATION | TO BE COMPLETED ONLY BY A STATE LICENSED MEDICAL PROFESSIONAL

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

- Heart       Ears       Nose       Teeth       Abdomen       Extremities       Hernia

( ) While this examination does not constitute a complete Medical Examination, it does on this date, and based upon my observation, meet the requirement for participation in this youth football program.

( ) Individual examined by me this date is considered not physically qualified to participate in this youth football program for the following

Reasons: \_\_\_\_\_

Examining Dr. \_\_\_\_\_ Office Phone \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

