



**SUPER PEEWEE LEAGUE  
2026 PHYSICAL FITNESS & MEDICAL HISTORY FORM**



**Special Note: This form must be dated after January 1, 2026 and then submitted to your Local Super Pee Wee organization. No other forms are acceptable. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.). By signing this form, the parent or legal guardian agrees to the terms and conditions outlined below.**

**Section I: FOR PARENT/GUARDIAN COMPLETION ONLY**

**Legal Name of Participant (must match birth certificate):**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Name of Primary Medical Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Membership Number \_\_\_\_\_

Name of Policy \_\_\_\_\_

Sport (check one): Cheer \_\_\_\_\_ Dance \_\_\_\_\_ Tackle \_\_\_\_\_

**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 inhaler?                    | Yes | No |
| 7. Is the participant diabetic/require medication for diabetes?                    | Yes | No |
| 8. Does the participant carry sickle cell trait/suffer from sickle cell disease?   | Yes | No |
| 9. Does the participant currently require medication?                              | Yes | No |
| 10. Does/has the participant have/had seizure?                                     | Yes | No |
| 11. Does the participant wear glasses or contact lenses?                           | Yes | No |
| 12. Does the participant have a brace or other medical support device?             | Yes | No |
| 13. Does the participant have any other physical limitations or medical condition? | Yes | No |

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space and/or attach to this form:

\_\_\_\_\_

\_\_\_\_\_

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 participant 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 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.

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

Print Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_

# SUPER PEEWEE LEAGUE

## Section II: THIS SECTION IS TO BE COMPLETED ONLY BY A MEDICAL PROFESSIONAL

Participant's Name: \_\_\_\_\_

(Please check the following if healthy or note otherwise):

<b>Height</b>	<b>Weight</b>	<b>Eye</b>
<b>Ears</b>	<b>Mouth</b>	<b>Nose &amp; Throat</b>
<b>Respiratory</b>	<b>Cardiovascular</b>	<b>Neurological</b>
<b>Musculoskeletal</b>	<b>Dermatological</b>	<b>Blood Pressure</b>

I hereby certify that I am a licensed state examiner and have examined the above name individual and understand that he/she will be involved in participating in **SUPER PEEWEE LEAGUE** 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 SUPER PEEWEE LEAGUE activities for the 2026 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 (MD., D.O.R.N., etc.) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Telephone \_\_\_\_\_

**This form is not to be used in any  
tournaments outside of the Miami-Dade/Broward Super**

