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 _____________________________

FLORIDA YOUTH FOOTBALL AND CHEERLEADING ASSOCIATION (FYFCA)

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
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes of asthma)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Do you think you are in good health?	☐	☐
6.	Have you ever passed ort or nearly passed out DURING exercises?	☐	☐
7.	Have you ever passed ort or nearly passes out AFTER exercise?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9.	Does you heart race or skip beats during exercise?	☐	☐
10.	Has a doctor ever told you that you have (check all that apply) ☐ High Blood Pressure ☐ A heart murmur ☐ High Cholesterol ☐ A heart infection		
11.	Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12.	Has anyone in your family died for no apparent reason?	☐	☐
13.	Does anyone in your family have a heart problem?	☐	☐
14.	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15.	Does anyone in your family have Marfan syndrome?	☐	☐
16.	Have you ever spent the night in a hospital?	☐	☐
17.	Have you ever had surgery?	☐	☐
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:	☐	☐
19.	Have you had any broken or fractured bones or dislocated joints, If yes, circle below:	☐	☐
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: __ Head ___ Elbow ___Hip ___ Chest ___ Thigh __ Back ___ Wrist ___ Knee ___ Forearm __ Shin/calf ___ Shoulder ___ Foot ___ Neck ___ Hand	☐	☐
21.	Have you ever had a stress fracture?	☐	☐
22.	Have you been told that you have or had an x-ray for atlantoazial (neck) instability?	☐	☐
23.	Do you regularly use a brace or assistive device?	☐	☐
24.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
25.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26.	Is there anyone in your family who has asthma?	☐	☐

		Yes	No
27.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
28.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31.	Have you had a herpes skin infection?	☐	☐
32.	Have you ever had a head injury or concussion?	☐	☐
33.	Have you been hit in the head and been confused or lost your memory?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Do you have headaches with exercise?	☐	☐
36.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
37.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
39.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40.	Have you had any problems with your eyes or vision?	☐	☐
41.	Do you wear glasses or contact lenses?	☐	☐
42.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
43.	Are you happy with your weight?	☐	☐
44.	Are you trying to gain or lose weight?	☐	☐
45.	Has anyone recommended you change your weight or eating habits?	☐	☐
46.	Do you limit or carefully control what you eat?	☐	☐
47.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
	FEMALES ONLY		
48.	Have you ever had a menstrual period?	☐	☐
49.	How old were you when you had your first menstrual period?	☐	☐
50.	How many periods have you had in the last 12 months?	☐	☐

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 ParentGuardian

____
Signature of Parent/Guardian

FLORIDA YOUTH FOOTBALL AND CHEERLEADING ASSOCIATION (FYFCA)

PHYSICAL EXAMINATION FORM

The section below is to be completed by physician after Health History and Parental/Guardian consent forms are completed. Please ensure the Physician signs and stamps.

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			
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 ____

FLORIDA YOUTH FOOTBALL AND CHEERLEADING ASSOCIATION (FYFCA)

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 _______________________________

Physician Stamp:

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 ___________________________________

FLORIDA YOUTH FOOTBALL AND CHEERLEADING ASSOCIATION (FYFCA)

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 _____________ 2012, by ________________, who is either personally known to me or provided_____________________as identification and who did take an oath.

____
Notary Public