2024-2025 YOUTH PARTICIPANT MEDICAL HISTORY FORM

Special Note: This form must be completed thoroughly and honestly, and signed by the youth participant's parent or legal guardian. It is to be completed and dated after January 1, 2024. This form applies to the 2024 Fall – 2025 Spring season and needs to be submitted to your LOCAL Pop Warner organization. This form and its contents will be available to authorized Pop Warner personnel and kept confidential. **By signing this form, the parent or legal guardian agrees to the terms and conditions outlined below.**

Section I: POP WARNER AFFILIATION

League: _____ Association: _____

Section II: YOUTH PARTICIPANT INFORMATION (must match birth certificate)

Last: _____ First: _____ Middle: _____

Date of Birth:_____ Age: _____ Male ☐ Female ☐ Sport: Football ☐ Cheer/Dance ☐

Section III: PRIMARY AND SECONDARY CONTACT

Primary Contact: Parent or Guardian

Last: _____ First: _____

Address: _____ City: _____ State: _____ Zip: _____

Mobile Phone No: _____ Alternate Phone No: _____

Email: _____ Relationship to Child: _____

Secondary Contact:

Last: _____ First: _____

Mobile Phone No: _____ Alternate Phone No: _____

Email: _____ Relationship to Child: _____

Section IV: INSURANCE INFORMATION

Primary Insurance Company: _____ Primary Group/Policy #: _____ / _____

Does primary insured have Medicaid? Yes ☐ No ☐ Does primary insured have Medicare? Yes ☐ No ☐

Family Doctor Name: _____ Doctor Phone No: _____

Section V: MEDICAL HISTORY OF THE YOUTH PARTICIPANT

Please identify and elaborate on any medical conditions which we should be aware (if none, write none):

_____

_____

_____

_____

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Please list any medications currently being taken (if none, write none):

_____

_____

In the past 24 months, has the participant been tested, diagnosed and/or treated for a concussion: Yes ☐ No ☐

If yes, provide the specific date and detail on the diagnoses/treatment and the outcome:

_____

_____

List any known allergies (if none, write none):

_____

_____

Date of last Tetanus Toxoid Booster: _____

The purpose of the above information is to ensure that medical personnel have details of any issues which may interfere with or alter medical treatment.

Section VI: PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE

Recognizing the possibility of serious injury, illness or death, and in consideration for Pop Warner Little Scholars, Inc. and its members accepting my child as a participant in its official programs, I consent to my child participating in Pop Warner tackle football, flag football, cheer and / or dance. Further, I hereby release, discharge, and otherwise indemnify Pop Warner, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my child as a result of participating in the Pop Warner programs.

My child has received a physical examination by a licensed health care provider within the past two years and has been found physically capable of participating in the sport of football and/or cheerleading & dance. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the programs. I give my consent to have an athletic trainer and/or licensed health care provider, including a medical doctor or dentist, provide my child with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

Signature of Parent/Guardian: _____ Date: _____

[PPWFA Addendum] MEDICAL SIGNATURE

Participant Name: _____

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be participating in Pop Warner football, cheer or dance programs. I hereby attest that this individual is physically fit and has no medical condition which would prevent this individual from participating in Pop Warner activities for the 2024 season. I am therefore clearing this individual for athletic participation without limitation.

Please indicate medical profession (M.D., D.O., R.N., etc.)_____

Are you licensed in your state to perform physical examinations? YES ☐ NO ☐

Today's Date:_____

Date of named individual's last physical: (must be after 1/1/2023 to be valid for 2024 Pop Warner season): _____

Please sign and fill out the following information OR place Official Medical Practice Stamp here:

Signature_____

Printed Name_____

Address_____City_____State_____Zip_____

Phone_____Fax:_____

Email/Website: Email_____(Optional)