

# Physical Examination

Central New York Pop Warner

# 2006

Pop Warner Season

Name:	Age:
Please Print legibly	

**1. Patient medical history: Has patient ever had any of the following? (Please answer Y or N)**

<input type="checkbox"/> Allergies	<input type="checkbox"/> Ear Problems	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eye trouble	<input type="checkbox"/> Loss of organ
<input type="checkbox"/> Birth defects	<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Surgical operation
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hospital stay	<input type="checkbox"/> Seizures
<input type="checkbox"/> Disease that runs in family	<input type="checkbox"/> Injury to back or joint	<input type="checkbox"/> Other _____

**2. If you have checked any of the above or have any other medical problems please explain below.**

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**3. Are there any other conditions not stated above that we should be aware of?**

If yes, please explain below. \_\_\_\_\_

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**DO NOT WRITE BELOW LINE / MEDICAL PERSONNEL ONLY**

BP	Pulse	Urine/Sugar	Acetone	Protein
Heart	Abdomen	Hernia		
Lungs	Back	Extremities		

Completion of this form is Physicians Statement of Fitness for participant to partake  
in Pop Warner Football, Cheerleading or Dance.

Date form completed  
\_\_\_\_ / \_\_\_\_ / 06

IT IS REQUIRED TO USE OFFICE STAMP OR  
PRINT PHYSICIANS NAME OFFICE ADDRESS & PHONE # BELOW

\_\_\_\_\_  
Physicians signature

M.D.