

**Well Cared for Child**  
**Medical Release form**  
Central New York Pop Warner

**2006**  
Pop Warner Season

Name: _____	Age: _____
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**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.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

If yes, please explain below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Date of Last Physical: \_\_\_\_\_

**Completion of this form is Physician's statement the he/she believes  
the above mentioned physical covered the industry standard  
for physical fitness to partake in the  
2006 pop warner football, cheerleading or dance season**

Date form completed

\_\_\_\_ / \_\_\_\_ / 06

M.D.

\_\_\_\_\_  
PHYSICIANS SIGNATURE

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