



Walter Hill Chargers



2025 PHYSICAL FITNESS & MEDICAL HISTORY FORM

Special Note: This form is to be dated after January 1, 2025 and then submitted to Walter Hill Chargers.

No other forms are acceptable. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.). Section II is modified or substituted ONLY to comply with local and/or state laws or medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to any modified/substituted form.

Section I: FOR PARENT/GUARDIAN COMPLETION ONLY

Legal Name of Participant (must match birth certificate):

Last: First: Middle:
Address: City: State: Zip:
Telephone No.: Date of Birth: Male: Female:
Name of Primary Medical Insurance Company: Policy Number:
Membership Number: Name of Primary Insured:
Does Primary insured have Medicaid? Yes No Does Primary insured have Medicare? Yes No
Sport (Circle One): Cheer Football

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 there any history of concussions and/or head injuries? | Yes | No |
| 4. Is the participant currently under the care of a medical practitioner? | Yes | No |
| 5. Is the participant currently taking any medications? | Yes | No |
| 6. Does the participant have any allergies (penicillin, bee stings, etc)? | Yes | No |
| 7. Does the participant have asthma/require the use of an inhaler? | Yes | No |
| 8. Is the participant diabetic/require medication for diabetes? | Yes | No |
| 9. Does the participant carry sickle cell trait/suffer from sickle cell disease? | Yes | No |
| 10. Does the participant currently require medication? | Yes | No |
| 11. Does/has the participant have/had seizures? | Yes | No |
| 12. Does the participant wear glasses or contact lenses? | Yes | No |
| 13. Does the participant wear a brace or other medical support device? | Yes | No |
| 14. Does the participant have any other physical limitations or medical conditions? | 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:

If you answered yes about concussions, provide the name of the doctor or qualified medical professional who cleared Participant for this activity:

I certify that this information is accurate. 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 participation at such time. Further, I 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's my responsibility to obtain written permission from my child's physician on official medical stationary in order for my child to resume participation after any and all such injury, illness or accident.

Signature of Parent or Legal Guardian:

Dated:

Print Name:

Relationship to Participant:



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Section II: **THIS SECTION MUST BE COMPLETED ONLY BY A LICENSED MEDICAL PROFESSIONAL ON OR AFTER JANUARY 1ST of the CURRENT CALENDAR YEAR.**

Name of Participant: _____

Date: _____

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

Height	Weight	Eyes
Ears	Mouth	Nose & Throat
Respiratory	Cardiovascular	Neurological
Musculoskeletal	Dermatological	Blood Pressure

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 Walter Hill Chargers football or cheer programs. I hereby attest that this individual is physically fit and has no medical condition which would prevent this individual from participating in WHC 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: _____

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: _____ (Optional)

Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc. – this may vary by state). NO other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/or state laws OR because of medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to any modified/substituted form that MUST be signed in the current calendar year.