

**2010 BYFL PHYSICAL FITNESS & MEDICAL HISTORY FORM**  
(This form must be handed into the coach by the second day of practice)

FOR PARENT/GUARDIAN COMPLETION ONLY

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 on Policy \_\_\_\_\_

PARTICIPANT MEDICAL HISTORY

- |   |     |    |
|---|-----|----|
| 1. Are there any injuries requiring medical attention?                              | Yes | No |
| 3. Is the participant currently under the care of a medical practitioner?           | Yes | No |
| 4. Is the participant currently taking any medications?                             | Yes | No |
| 5. Does the participant have any allergies (penicillin, bee stings, etc)?           | Yes | No |
| 6. Does the participant have asthma/require the use of an inhaler?                  | Yes | No |
| 8. Does the participant currently require medication                                | Yes | No |
| 9. Does/has the participant have/had seizures?                                      | Yes | No |
| 10. Does the participant wear glasses or contact lenses?                            | Yes | No |
| 12. 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:

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I hereby certify that this information is accurate to the best of my knowledge. 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. Furthermore, I hereby 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 is my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signed \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship to Participant \_\_\_\_\_

Dated \_\_\_\_\_