

Name of Participant:

MT BALDY CONFERENCE 2025 PHYSICAL FITNESS & MEDICAL HISTORY FORM



Weight

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

This form 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).

Height

Respiratory Cardiovascular Neurological Blood Pressure Musculoskeletal Dermatological Notes: 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 2025 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: Email (Optional)	(Please check the follows	ing if healthy or note otherwis	e):		
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Please sign and fill out the following information OR place Official Medical Practice Stamp here: Signature Printed Name Address City State Zip Phone Fax:					
Please sign and fill out the following information OR place Official Medical Practice Stamp here: Signature Printed Name Address City StateZip PhoneFax:			minations? YES \square	NO 🗆	
Signature	Today's Date:				
Printed Name Address City StateZip Phone Fax:	Please sign and fill	out the following inform	nation OR place Offic	cial Medical Practice Sta	mp here:
Address City State Zip Phone Fax:	Signature				
PhoneFax:	Printed Name				
	Address_		City	StateZip	
Email/Website: Email(Optional)	Phone	Fax:_			
	Email/Website: Email		(Optiona	al)	

Note to Pop Warner participants: If you're uploading this signed document directly into your participant profile within the Sports Connect roster system, please make sure each page includes a proper signature. It will not be accepted without signatures. Documents can be scanned as PDF files from your smartphone or tablet. CLICK HERE to learn how.