PITT-GREENVILLE TITAN YOUTH FOOTBAL

This form is to be filled out completely and filed with the League before applicant can participate in any practices, games, etc.

PARTICIPANTS' NAME: _____ Date of Birth (MM/DD/YY)_____

As parent or legal guardian of Participant, I herby give my consent for his/her participation in the athletic events listed on this form. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand every effort will be made to contact me prior to treatment. I agree to the need for screening medical examination and certify that the medical history is accurate to the best of my knowledge. I also understand this examination is a limited medical checkup to screen your child to see if he/she can safely participate in sports. The exam does screen for the common problems that have been shown to be a danger to athletes. It is not a comprehensive medical exam and often does not detect rare medical conditions. If you have concerns about your child having a serious medical illness, please schedule a visit with your personal physician.

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

MEDICAL HISTORY

Athlete's Directions: Please review all questions with your parent or guardian and answer them to the best of your knowledge.

1.	Has anyone in the athlete's family (grandmother, mother, father, brother, sister, aunt, uncle), died suddenly before age 50?	Yes	No	Don't Know
2.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?	Yes	No	Don't Know
3.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?	Yes	No	Don't Know
4.	Has the athlete ever had a bone broken, had to wear a cast, or had an injury to any joint?	Yes	No	Don't Know
5.	Does the athlete have a history of a concussion (being knocked out)?	Yes	No	Don't Know
6.	Has the athlete ever suffered a heat-related illness (heat stroke)?	Yes	No	Don't Know
7.	Does the athlete have anything he/she wants to talk to the doctor about?	Yes	No	Don't Know
8.	Does the athlete have a chronic illness or see a doctor regularly for any particularly problem?	Yes	No	Don't Know
9.	Does the athlete take any medicine?	Yes	No	Don't Know
10.	Is the athlete allergic to any medication or bee stings?	Yes	No	Don't Know
11.	Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?	Yes	No	Don't Know

Elaborate on any positive answers:

MEDICAL EXAMINATION

Height: _____ Weight:_____ Blood Pressure:_____

	Normal	Abnormal	Description of Abnormals
Musculoskeletal Exam:			
	☐	☐	Knee
	☐	☐	Ankle
	☐	☐	Shoulder
	☐	☐	Other Joints
	☐	☐	Alignment Problems
	☐	☐	Scoliosis
	☐	☐	Feet
	☐	☐	Estimate of Strength
	☐	☐	Estimate of Flexibility
Eyes:	☐	☐	
Genitalia (males):	☐	☐	
Cardiovascular Exam:	☐	☐	

Other Exam (if indicated by history):

ASSESSMENT: ☐ No problem identified ☐ Other
RECOMMENDATION: ☐ Unlimited ☐ Limited to_____
☐ Deferred until:_____(e.g. rehab, recheck, consultation, lab, etc.)

I certify that I have examined the above named participant and that such examination revealed (conditions / no conditions) that would prevent this participant from participation in the sport listed above.

Licensed to practice medicine in North Carolina? YES NO

Signature:_____ Address:_____
Date:_____

If applicant does not qualify, list reasons for disqualification:_____