



## 2024-2025 YOUTH PARTICIPANT MEDICAL HISTORY FORM

**Special Note:** This form must be completed thoroughly and honestly, and signed by the youth participant's parent or legal guardian. It is to be completed and dated after January 1, 2024. This form applies to the 2024 Fall – 2025 Spring season and needs to be submitted to your LOCAL Pop Warner organization. This form and its contents will be available to authorized Pop Warner personnel and kept confidential. **By signing this form, the parent or legal guardian agrees to the terms and conditions outlined below.**

### Section I: POP WARNER AFFILIATION

League: Sagebrush Pop Warner Association: Reno Sparks Pop Warner

### Section II: YOUTH PARTICIPANT INFORMATION (must match birth certificate)

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male  Female  Sport: Football  Cheer/Dance

### Section III: PRIMARY AND SECONDARY CONTACT

*Primary Contact: Parent or Guardian*

Last: \_\_\_\_\_ First: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mobile Phone No: \_\_\_\_\_ Alternate Phone No: \_\_\_\_\_  
Email: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

*Secondary Contact:*

Last: \_\_\_\_\_ First: \_\_\_\_\_  
Mobile Phone No: \_\_\_\_\_ Alternate Phone No: \_\_\_\_\_  
Email: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

### Section IV: INSURANCE INFORMATION

Primary Insurance Company: \_\_\_\_\_ Primary Group/Policy #: \_\_\_\_\_ / \_\_\_\_\_  
Does primary insured have Medicaid? Yes  No  Does primary insured have Medicare? Yes  No   
Family Doctor Name: \_\_\_\_\_ Doctor Phone No: \_\_\_\_\_

### Section V: MEDICAL HISTORY OF THE YOUTH PARTICIPANT

Please identify and elaborate on any medical conditions which we should be aware (if none, write none):

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Please list any medications currently being taken (if none, write none):

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In the past 24 months, has the participant been tested, diagnosed and/or treated for a concussion: Yes  No

If yes, provide the specific date and detail on the diagnoses/treatment and the outcome:

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List any known allergies (if none, write none):

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Date of last Tetanus Toxoid Booster: \_\_\_\_\_

*The purpose of the above information is to ensure that medical personnel have details of any issues which may interfere with or alter medical treatment.*

### **Section VI: PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE**

Recognizing the possibility of serious injury, illness or death, and in consideration for Pop Warner Little Scholars, Inc. and its members accepting my child as a participant in its official programs, I consent to my child participating in Pop Warner tackle football, flag football, cheer and / or dance. Further, I hereby release, discharge, and otherwise indemnify Pop Warner, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my child as a result of participating in the Pop Warner programs.

My child has received a physical examination by a licensed health care provider within the past two years and has been found physically capable of participating in the sport of football and/or cheerleading & dance. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the programs. I give my consent to have an athletic trainer and/or licensed health care provider, including a medical doctor or dentist, provide my child with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_