



2026 NTYBA PHYSICAL FITNESS & MEDICAL HISTORY FORM

Special Note: This form must be dated after January 1, 2026, and then submitted to the North Tyler Youth Baseball Association. 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 the modified/substituted form. Section II must be completed in its entirety **ONLY** by a Licensed State Examiner (medical doctor, nurse practitioner, RN, LVN, etc.)

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: _____

PARTICIPANT MEDICAL HISTORY

Are there any injuries that require medical attention?	Yes	No
Are there any past surgeries or scheduled surgeries?	Yes	No
Is the participant currently under the care of a medical practitioner?	Yes	No
Is the participant currently taking any medication?	Yes	No
Does the participant have any allergies (penicillin, bee stings, etc)?	Yes	No
Does the participant have asthma/require the use of an inhaler?	Yes	No
Is the participant diabetic/require medication for diabetes?	Yes	No
Does the participant currently require medication?	Yes	No
Does/have the participant have/had seizures?	Yes	No
Does the participant wear glasses or contact lenses?	Yes	No
Does the participant wear braces or other medical support devices?	Yes	No
Does the participant have any other physical limitations/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:

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 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 or official medical licensed state examiner to seek permission for my child to resume participation after any such injury, illness, or accident.

Signature of Parent or Legal Guardian: _____

Print Name _____

Relationship to Participant _____

Date _____

Section II: THIS SECTION IS TO BE COMPLETED ONLY BY A MEDICAL PROFESSIONAL

Name of Participant: _____

(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 involved in participating in NTYBA baseball program. I hereby swear and attest that this individual is physically fit, and I have found no medical reason that would prevent this individual from safely participating in NTYBA activities for the 2026 season. I am therefore clearing this individual for athletic participation without limitation.

Please place a medical professional stamp here or fill out the following:

Signed _____ Date: _____

Print Name _____

Please indicate medical profession (M.D., D.O., R.N., LVN, etc.) _____

Complete this section, or the medical professional's stamp may be placed below.

Address _____ City _____ State _____

Telephone _____ /Fax Number: _____

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