

PACIFIC YOUTH FOOTBALL LEAGUE

PLAYER/CHEERLEADER PHYSICAL FORM

Season: 2011

Chapter: S.C.V.A.A.

Section I: PHYSICAL DESCRIPTION & CONDITION

PARENTS PLEASE FILL THIS SECTION OUT

Participant Name: _____ Male Female
First Last Circle One

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Hair Color: _____ Eye Color: _____

Sport (Check One) Football _____ Cheerleader _____ Date of Birth: _____

Section II: HEALTH HISTORY

PARENTS PLEASE FILL THIS SECTION OUT

Family Physician: _____ Phone: _____

Other Caregiver: _____ Phone: _____

Medications: _____ Allergies: _____

- | | | |
|---|-----|----|
| 1. Are there any injuries requiring medical attention? | Yes | No |
| 2. Does the participant have any allergies (penicillin, bee stings, etc)? | Yes | No |
| 3. Does the participant have asthma/require the use of an inhaler? | Yes | No |
| 4. Is the participant diabetic/require medication for diabetes? | Yes | No |
| 5. Does/has the participant have/had Seizures? | Yes | No |
| 6. Does/has the participant have/had Kidney Issues? | Yes | No |
| 7. Does/has the participant have/had Heart Issues? | Yes | No |
| 8. Does/has the participant have/had a Head Injury? | Yes | No |
| 9. Does/has the participant have/had a Shoulder/Hip Injury? | Yes | No |
| 10. Does the participant have any other physical limitations or medical conditions? | Yes | No |

Section III: MEDICAL EXAMINATION

PHYSICIAN PLEASE FILL THIS SECTION OUT

Height _____ Weight _____ Blood Pressure _____ / _____ Temp _____

Mouth/Teeth _____ Nose/Throat _____ Dermatological _____

Respiratory _____ Neurological _____ Muskoskeletal _____

Cardiovascular _____ Abdomen _____ Hernia _____

REMARKS: Please check appropriate block.

While this examination does not constitute a complete Medical Examination, it does on this date, on my observations, meet the requirements for participation in the youth football program.

The individual examined by me on this date is considered "not" physically qualified to participate in this youth football/cheer program for the following reasons.

PHYSICIAN PLEASE FILL THIS SECTION OUT

EXAMINED BY: _____

ADDRESS: _____

SIGNATURE: _____

CITY: _____ ZIP: _____

DATE: _____

PHONE: _____ STATE: _____