PHYSICAL EXAMINATION & MEDICAL HISTORY
Central Coast Youth Football League

Child's Name:_____ **Age:**_____
Date of Birth:_____ **Verified by Birth Certificate: Yes__ No__**

Physical Examination

PHYSICIAN: Your careful examination and written recommendations will encourage personal fitness and safety participation in strenuous sports activities. Please complete the following physical evaluation, and review medical history with subject player.

Normal		Abnormal	Explanation if Abnormal
( )	Abdomen	( )	_____
( )	Blood Pressure_____	( )	_____
( )	Ears	( )	_____
( )	Extremities	( )	_____
( )	Eyes	( )	_____
( )	Genitalia	( )	_____
( )	Heart	( )	_____
( )	Lungs	( )	_____
( )	Nose	( )	_____
( )	Skin	( )	_____
( )	Spine (posture)	( )	_____
( )	Teeth	( )	_____
( )	Throat	( )	_____
( )	Vision	( )	_____
( )	Height	( )	_____
( )	Weight _____lbs.	( )	_____

Medical History

CHECK MARK any of the following illness or symptoms that have occurred to the subject player in the past, or at the present time:

( ) Asthma ( ) Fainting ( ) Convulsions( ) Diabetes( ) Heart Problems ( ) Headaches ( ) Surgery_____( ) Medication Reaction_____( ) None of the above

I certify that I have reviewed the medical history and examined the subject player and find him___her___ physically fit to participate in competitive sport activities.

***Signature of Physician*:**_____ **Date:**_____

In the event of injury or illness to my child,_____,I hereby grant authorization to a qualified physician to render such medical attention as said physician deems necessary.

_____ **Date:**_____**Emergency Phone #**_____
Signature of Parent/Legal Guardian

--- (White copy to Chapter --- Yellow copy to Head Coach --- Pink copy to Parent) ---