

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
<input type="checkbox"/>	Abdomen	<input type="checkbox"/>		_____
<input type="checkbox"/>	Blood Pressure _____	<input type="checkbox"/>		_____
<input type="checkbox"/>	Ears	<input type="checkbox"/>		_____
<input type="checkbox"/>	Extremities	<input type="checkbox"/>		_____
<input type="checkbox"/>	Eyes	<input type="checkbox"/>		_____
<input type="checkbox"/>	Genitalia	<input type="checkbox"/>		_____
<input type="checkbox"/>	Heart	<input type="checkbox"/>		_____
<input type="checkbox"/>	Lungs	<input type="checkbox"/>		_____
<input type="checkbox"/>	Nose	<input type="checkbox"/>		_____
<input type="checkbox"/>	Skin	<input type="checkbox"/>		_____
<input type="checkbox"/>	Spine (posture)	<input type="checkbox"/>		_____
<input type="checkbox"/>	Teeth	<input type="checkbox"/>		_____
<input type="checkbox"/>	Throat	<input type="checkbox"/>		_____
<input type="checkbox"/>	Vision	<input type="checkbox"/>		_____
<input type="checkbox"/>	Height	<input type="checkbox"/>		_____
<input type="checkbox"/>	Weight _____ lbs.	<input type="checkbox"/>		_____

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) ---