

# Northwest Vikings Youth Football Physical Form

This form is to be filled out completely and filed with NWYFA before applicant can participate in any practices, games, etc.

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

As parent or legal guardian of Participant, I hereby give my consent for his/her participation in the athletic events listed on this form. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand every effort will be made to contact me prior to treatment. I agree to the need for screening medical examination and certify that the medical history is accurate to the best of my knowledge. I also understand this examination is a limited medical checkup to screen your child to see if he/she can safely participate in sports. The exam does screen for the common problems that have been shown to be a danger to athletes. It is not a comprehensive medical exam and often does not detect rare medical conditions. If you have concerns about your child having a serious medical illness, please schedule a visit with your personal physician.

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

Participant's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

## Medical History

Athlete's Directions: Please review all questions with your parent or guardian and answer them to the best of your knowledge.

- |   |     |    |            |
|---|-----|----|------------|
| 1. Has anyone in the athlete's family (grandmother, mother, father, brother, sister, aunt, uncle), died suddenly before age 50? | Yes | No | Don't Know |
| 2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise?                                  | Yes | No | Don't Know |
| 3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?                                       | Yes | No | Don't Know |
| 4. Has the athlete ever had a bone broken, had to wear a cast, or had an injury to any joint?                                   | Yes | No | Don't Know |
| 5. Does the athlete have a history of a concussion (being knocked out)?   | Yes | No | Don't Know |
| 6. Has the athlete ever suffered a heat-related illness (heat stroke)?  | Yes | No | Don't Know |
| 7. Does the athlete have anything he/she wants to talk to the doctor about?   | Yes | No | Don't Know |
| 8. Does the athlete have a chronic illness or see a doctor regularly for any particularly problem?                              | Yes | No | Don't Know |
| 9. Does the athlete take any medicine?  | Yes | No | Don't Know |
| 10. Is the athlete allergic to any medication or bee stings?  | Yes | No | Don't Know |
| 11. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)?                         | Yes | No | Don't Know |

Please explain all "Yes" answers—use the back if necessary.

## Medical Examination

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Musculoskeletal Exam:	Abnormal Findings	Additional Exams:	Abnormal Findings
<input type="checkbox"/> Knee		<input type="checkbox"/> Eyes:	
<input type="checkbox"/> Ankle		<input type="checkbox"/> Genitalia (males):	
<input type="checkbox"/> Shoulder		<input type="checkbox"/> Cardiovascular:	
<input type="checkbox"/> Other Joints		<input type="checkbox"/> Other (if indicated by history):	
<input type="checkbox"/> Alignment Problems			
<input type="checkbox"/> Scoliosis			
<input type="checkbox"/> Feet			
<input type="checkbox"/> Estimate of Strength			
<input type="checkbox"/> Estimate of Flexibility			

ASSESSMENT: I certify that I have examined this child and find him/her medically:

**QUALIFIED** to participate (no conditions that would prevent this participant from participation)

**NOT QUALIFIED** to participate for the following reasons \_\_\_\_\_

Licensed to practice medicine in North Carolina? **YES** **NO**

Doctor Name (printed): \_\_\_\_\_ Doctor Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Date: \_\_\_\_\_

Send a copy to: ORYA/NWYFA P.O. Box 370, Oak Ridge, NC 27310