



Physical Form (Must be for this calendar year, dated after April 1st)

Childs Name: _____ Age: _____

Date of Birth: ___/___/___

Any Known Allergies: Yes/No. If yes, please list allergies: _____

Any Known Disabilities: Yes/No. If yes, please list any: _____

Physicians Statement of Health:

I certify that I have examined _____

and have found no gross evidence of any abnormality that will keep him/her from participating in the Youth Sports Program.

Physicians Name: _____

Address: _____ Phone _____

Signature: _____ Date: _____



Physical Form (Must be for this calendar year, dated after April 1st)

DOCTOR STAMP REQUIRED HERE TO BE VALID