



PHYSICAL EXAMINATION FORM

Child's Name: _____

Parent/Guardian Name: _____

Address: _____ Zip: _____

Phone Number: _____ Child's Date of Birth: _____

Name of Child's Physician: _____

Physician's Phone Number: _____

Has your child ever had any of the following:

Allergies: Yes No If so, what type: _____

Operations: Yes No If so, what type: _____

Recurring Illness: Yes No If so, what type: _____

Any history of Rheumatic or Scarlet Fever: Yes No

Is your child currently under medical treatment: Yes No

If yes, what is the child being treated for:

List any medical problems that the coaches should be aware of:

Parent / Guardian Signature: _____ Date: _____

PHYSICAL EXAMINATION PORTION BELOW

(TO BE COMPLETED BY DOCTOR)

Weight: _____ Height: _____ BP & Pulse: _____

General Nutrition

| | | |
|------------------|---------------------------------|-----------------------------------|
| Skin: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Eyes: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Ears: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Nose: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Throat: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Teeth/Gums: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Glands: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Heart: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Abdomen: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Genitalia Male: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Neuros Muscular: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |

Should this child have any restrictions on football participation: Yes No

If Yes, Details:

Physician's Signature: _____

Date: _____