

YOUTH DEVELOPMENT FOOTBALL LEAGUE

Athletic Participation Physical Examination Form

Part I - Athletic Participation Male _____ Female _____ Date _____
 (To be filled in and signed by the Parent)

Name _____
 Home Address _____
 City / Zip Code _____
 Home Phone _____
 Emergency Contact # _____
 Date of Birth _____
 Place of Birth _____
 School attending in the fall _____

Part II - MEDICAL HISTORY

*** This form must be completed by parent or guardian **prior to the physical examination** and should be taken to the physical examination for review by the physician during the examination.

- | YES | NO | |
|-------|-------|---|
| _____ | _____ | 1. Have you ever had any of the following ? Please explain any Yes answers |
| _____ | _____ | heart Murmur _____ |
| _____ | _____ | high blood pressure _____ |
| _____ | _____ | other heart problems _____ |
| _____ | _____ | broken bones _____ |
| _____ | _____ | weak joints - ankles, knees _____ |
| _____ | _____ | concussion _____ |
| _____ | _____ | operation _____ |
| _____ | _____ | seizures or epilepsy _____ |
| _____ | _____ | 2. Have you ever fainted or passed out ? _____ |
| _____ | _____ | 3. Have you ever been knocked out / been unconscious _____ |
| _____ | _____ | 4. Have you ever been hospitalized ? _____ |
| _____ | _____ | 5. Have you ever had to stop running after ¼ to ½ miles for chest pain or shortness of breath ? _____ |
| _____ | _____ | 6. A. Have you ever had significant allergies to: |
| _____ | _____ | bee stings ? - and do you need medication if stung - yes ___ no ___ |
| _____ | _____ | foods _____ |
| _____ | _____ | medicine _____ |
| _____ | _____ | others _____ |
| _____ | _____ | B. Do you have prescriptions for use of: |
| _____ | _____ | Adrenaline or epinephrine _____ |
| _____ | _____ | Inhalers _____ |
| _____ | _____ | Other allergy medicine _____ |
| _____ | _____ | C. Do you have asthma ? _____ |
| _____ | _____ | 7. Do you take any medicine regularly ? If so, which ones ? _____ |
| _____ | _____ | 8. Have you had any illness lasting a week or more such as mononucleosis, etc. _____ |
| _____ | _____ | 9. Have you had any blood disorders, including sickle cell trait, anemia, etc. ? _____ |

YES	NO	10.	Has any family member had a heart attack, heart problems or sudden death before the age of 50 ? _____
_____	_____	11.	Do you wear contact lenses, eyeglasses or dental appliances ? _____
_____	_____	12.	Do you have any missing or non - functioning organs such as eye, kidney, etc. _____
_____	_____	13.	Do you have any other significant health problems ? _____
_____	_____	14.	Have you had the Hepatitis B Immunization Series ? _____
_____	_____	15.	DATE OF LAST TETANUS IMMUNIZATION ? _____

I certify all the above information is correct.

Parent / Guardian Signature: _____ Date _____

PART III - PHYSICAL EXAMINATION

(To be completed and signed by examining physician)

HEIGHT _____ WEIGHT _____ GENDER M/F AGE _____ GRADE _____ BP _____
 *PULSE (REST) _____

HEENT _____
 NECK _____
 HEART _____
 LUNGS _____
 ABDOMEN _____
 * GENITALIA / HERNIA _____
 MUSCULOSKELETAL
 SHOULDERS _____
 ARMS / WRIST / HAND / ELBOWS _____
 KNEES / HIPS _____
 ANKLES _____
 SPINE / BACK _____
 * LYMPHATICS _____
 * PERIPHERAL PULSES _____

* When medically indicated.

I have reviewed the data above , reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

_____ Full Participation _____ Limited Participation
 _____ No Participation _____ Needs Additional Evaluation

If not full participation give reasons & recommendations: _____

Any recommendations or concerns on such items as: _____

 Physician Phone Date