

# SAN DIEGO YOUTH FOOTBALL AND CHEER CONFERENCE, INC.

PHYSICAL EXAMINATION FORM MUST BE DATED AFTER JANUARY 1<sup>ST</sup> OF THE CURRENT SEASON PER AYF RULES

ASSOCIATION NAME: \_\_\_\_\_ DIVISION: F MM JPW PW JM MID UNL  
(PRINT) (CIRCLE ONE)

Athlete's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Phone \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ Family \_\_\_\_\_ Dr.'s \_\_\_\_\_  
Dr. \_\_\_\_\_ Phone \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE \_\_\_\_\_

The above named athlete has my permission to participate in San Diego Youth Football and Cheer Conference, Inc. activities and has permission to travel with a representative of San Diego Youth Football and Cheer Conference, Inc. and the local Association on any trips. In case of injury a San Diego Youth Football and Cheer Conference, Inc. representative is authorized to have him/her treated and/or hospitalized by any one of the doctors cooperating with San Diego Youth Football and Cheer Conference, Inc., and will not hold San Diego Youth Football and Cheer Conference, Inc., the local Association or its representatives responsible for payment as the result of any accident or injury.

### Medical History (to be completed by parent/guardian)

R or L Handed \_\_\_\_\_ Allergies to medications \_\_\_\_\_

#### Has athlete had the following:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Injuries to head, neck, bones or joints               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Any other injuries requiring medical attention        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Seizures, blackouts or any episode of unconsciousness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Heart trouble, heart murmur, high blood pressure      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Any serious infectious disease                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Hospitalization or operations in the past             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Stomach, intestinal, or urinary tract problems        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Is athlete under care of a doctor now                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Is athlete taking any medication on a regular basis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Any dental problems                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Explain "Yes" Answers  
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\_\_\_\_\_  
\_\_\_\_\_

Parent or Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Physical Examination (to be completed by physician)

DATE OF PHYSICAL: \_\_\_\_\_  
HEIGHT: \_\_\_\_\_  
WEIGHT: \_\_\_\_\_  
BLOOD PRESSURE: \_\_\_\_\_  
PULSE: \_\_\_\_\_  
GENERAL APPEARANCE: \_\_\_\_\_  
DERM: \_\_\_\_\_

HEAD: \_\_\_\_\_  
NECK: \_\_\_\_\_  
HEART: \_\_\_\_\_  
LUNGS: \_\_\_\_\_  
CHEST (INCLUDING BREASTS): \_\_\_\_\_  
ABDOMEN: \_\_\_\_\_  
GENETALIA: \_\_\_\_\_  
BACK & EXTREMETIES: \_\_\_\_\_  
NEUROLOGICAL: \_\_\_\_\_

By my signature below, I certify that I am licensed by the state and am qualified in determining that the above named athlete is physically fit and that I have found no medical or observable conditions which would contra-indicate him/her from participating in youth flag football, tackle football, cheer, dance or athletic activities. I am therefore clearing this individual for athletic participation.

Dr. Office Seal Or Stamp Here.  
If "NONE" Then Attach The  
Doctor's Business Card Here  
(Required).

CLEARED  YES  NO

Is further consultation necessary?  Yes  No Specialty \_\_\_\_\_

Physician's Signature \_\_\_\_\_ M.D. Date \_\_\_\_\_ Phone \_\_\_\_\_