



Physical Examination Form

BIXBY YOUTH FOOTBALL ASSOCIATION

PARTICIPANTS NAME _____ DATE _____

PARENT/GUARDIAN _____

PARTICIPANTS HEALTH HISTORY

DOES PARTICIPANT HAVE?	YES	NO	IF YES, PLEASE EXPLAIN
HEADACHES/DIZZINESS/FAINTING	()	()	_____
NOSEBLEEDS/HIGH BLOOD PRES	()	()	_____
ALLERGIES	()	()	_____
ASTHMA	()	()	_____
HEARING PROBLEMS	()	()	_____
CHRONIC/REOCCURRING ILLNESS	()	()	_____
HERNIA	()	()	_____
BONE,JOINT,OR SPINE INJURY	()	()	_____
LIVER,SPLEEN,KIDNEY PROBLEMS	()	()	_____
ORGANS MISSING	()	()	_____
TAKING MEDICATIONS	()	()	_____

LIST, IF ANY, PHYSICAL OR MENTAL LIMITATIONS THAT MIGHT PREVENT PARTICIPATION IN TACKLE FOOTBALL:

The above information is true and correct: _____

PARENT/GUARDIAN SIGNATURE

PHYSICIAN'S EXAMINATION

HEIGHT: _____ WEIGHT: _____ BP: _____ HEART: _____ PULSE: _____

EENT: _____ LUNGS: _____ STRUCTURAL: _____

MOBILITY:(KNEES,JOINTS,ETC) _____ OTHER: _____

PHYSICIAN'S COMMENTS: _____

SPORTS PARTICIPATION APPROVED:(CIRCLE) **YES** **NO**

PHYSICIAN'S SIGNATURE: _____ DATE: _____