CTYFL Sports Physical Form

Name:		Gender: M	F	Date of	Birth: _	//	
Father's/Guardian's Name:			Contact N	umber:			
Mother's/Guardian's Name:							
Address:							
City: State: Zip Code:				Home Phone:			
Alternate Emergency Contact:			Daytime Phone:				
MEDICAL ALERTS (Allergic Reactions, Cont							
Medical History:							
Parents - This health record is a critical elem	nent in the d	etermination of an a	thlete's risk o	f injury in	sports.		
Please read and answer all the questions before	lete's physica	l examinat	ion.				
				YES	NO	Don't Know	
1) Has anyone in the athlete's family (grandpardied suddenly before age 50?	rents, mother,	father, brother, sister,	aunt, uncle)				
2) Has the athlete ever stopped exercising beca	use of dizzine	ess or passed out durin	g exercise?				
3) Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?							
4) Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any							
5) Does the athlete have a history of concussion or head injury?							
6) Has the athlete ever suffered a heat-related illness (heat exhaustion/heat stroke)?							
7) Does the athlete have a chronic illness or sec	ar problem?						
8) Does the athlete take any medication(s)?							
9) Is the athlete allergic to any medications or b							
10) Does the athlete have only one of any paired	les, ovaries)						
11) Has the athlete had an injury in the last year consecutive days of practice or competition?		ne athlete to miss 3 or	more				
12) Has the athlete had surgery or been hospitali	ized in the pas	st year?					
13) Has the athlete missed more than 5 consecut because of illness, or has the athlete had a m resolved in the past year?		•					
14) Are you, the athlete, worried about any prob	lem or conditi	ion at this time?					
Please give details on any "YES" answer	from the abo	ove health history:					

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PHYSICAL EXAMINATION FORM

Height:	Vision:	Right	Left		
Weight:	Uncorrected:	/	/		
Pulse:		/			
Blood Pressure:					
	Normal	Abnorma	al Findings	Initials	
1) Eyes					
2) Ears, Nose, Throat					
3) Mouth & Teeth					
4) Neck					
5) Cardiovascular					
6) Chest & Lungs					
7) Abdomen					
8) Skin					
9) Genitalia / Hernia (Male)					
10) Musculoskeletal					
a) Neck					
b) Spine					
c) Shoulders					
d) Arms/Hands					
e) Hips					
f) Thighs					
g) Knees					
h) Ankles					
i) Feet					
11) Neuromuscular					
Please Print / Stamp - This Form	nust be signed by o	a licensed physician, physicio	an's assistant or nurse practioner.		
Examiner's Name					
Street Address					
City State 7in	Telephone				
I certify that I have examined this a	athlete and found h	im/her medically qualified to	participate in sports. I also certify	that	
I am a licensed medical physician,		• •			
(Doctor of Chiropractic Medicine i	s not satisfactory.)				
Examiner's Signature			Date _		
n et e n et e					
Participation Restrictions:					