NORTH HILLS YOUTH FOOTBALL ASSOCIATION

The Tradition Starts Here!

PHYSICAL EXAMINATION FORM

Player'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)

Player's Name: _____

Weight: _____ Height: _____ BP & Pulse: _____

General Nutrition

Skin:	Normal ☐	Abnormal ☐
Eyes:	Normal ☐	Abnormal ☐
Ears:	Normal ☐	Abnormal ☐
Nose:	Normal ☐	Abnormal ☐
Throat:	Normal ☐	Abnormal ☐
Teeth/Gums:	Normal ☐	Abnormal ☐
Glands:	Normal ☐	Abnormal ☐
Heart:	Normal ☐	Abnormal ☐
Abdomen:	Normal ☐	Abnormal ☐
Genitalia Male:	Normal ☐	Abnormal ☐
Neuros Muscular:	Normal ☐	Abnormal ☐

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

If Yes, Details:

_____

_____

Physician's Signature: _____

Date: _____