DESERT VALLEY YOUTH FOOTBALL AND CHEER CONFERENCE
PHYSICAL EXAMINATION FORM

ORIGINAL OF THIS FORM IS REQUIRED TO COMPLETE YOUR REGISTRATION

ASSOCIATION NAME: Holtville Youth Football and Cheer Assn **DIVISION:** _____

Athlete's Name: _____ **Birth date:** _____
LAST FIRST MI

Athlete's Address: _____ **Family Dr.:** _____ **Dr.'s Phone:** _____

The above named athlete has my permission to participate in the Desert Valley Youth Football and Cheer Conference, activities and has permission to travel with a representative of the Desert Valley Youth Football and Cheer Conference, and the local Association on any trips. In case of injury a Desert Valley Youth Football and Cheer Conference, representative is authorized to have him/her treated and/or hospitalized by any one of the doctors cooperating with the Desert Valley Youth Football and Cheer Conference, and I will not hold the Desert Valley Youth Football and Cheer Conference, Holtville Youth Football and Cheer 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 Medication:** _____

Has athlete had/have the following:	Circle one:	Explain "Yes" Answers
1. Injuries to head, neck, bones or joints	Yes No	
2. Any other injuries requiring medical attention	Yes No	
3. Seizures, blackouts or any episode of unconsciousness	Yes No	
4. Heart trouble, heart murmur, high blood pressure	Yes No	
5. Hospitalization or operations in the past	Yes No	
6. Any Serious Infectious Disease	Yes No	
7. Stomach, intestinal, or urinary tract problems	Yes No	
8. Is athlete under care of a doctor now	Yes No	
9. Is athlete taking any medication on a regular basis	Yes No	
10. Any dental problems	Yes No	
11. Does the athlete have Asthma	Yes No	
12. Any allergies *(please list **ALL** food, insect or medicine)*	Yes No	

Parent or Legal Guardian Signature: _____ **Date:** _____

Physical Examination (to be completed by physician)

Date of physical: _____

Height: _____ **Weight:** _____

Blood Pressure: _____ **Pulse:** _____

☐ **Heart** ☐ **Ears** ☐ **Nose** ☐ **Teeth** ☐ **Abdomen** ☐ **Extremities**

Remarks: _____

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

☐ **While this examination does not constitute a complete Medical Examination, it does on this date and based on my observation, meet the requirement for participation in this youth football program.**

☐ **Individual examined by me on this date is considered NOT physically qualified to participate in this youth football program for the following reasons:** _____

_____

Physician's Signature: _____ **M.D. Date:** _____ **Phone** _____