

2007 PHYSICAL - STOKESDALE YOUTH FOOTBALL ASSOCIATION

This form is to be filled out completely and filed with the Stokesdale Youth Football Association (SYFA) before applicant can participate in any practices, games, etc.

PARTICIPANTS' NAME: _____ Date of Birth (MMDDYY) _____

As parent or legal guardian of Participant, I hereby give my consent for his/her participation in the athletic events listed on this form. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand every effort will be made to contact me prior to treatment. I agree to the need for screening medical examination and certify that the medical history is accurate to the best of my knowledge. I also understand this examination is a limited medical checkup to screen your child to see if he/she can safely participate in sports. The exam does screen for the common problems that have been shown to be a danger to athletes. It is not a comprehensive medical exam and often does not detect rare medical conditions. If you have concerns about your child having a serious medical illness, please schedule a visit with your personal physician.

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

FAMILY PHYSICIAN _____ PHONE _____
 INSURANCE _____ POLICY NUMBER _____

MEDICAL HISTORY

Athlete's Directions: Please review all questions with your parent or guardian and answer them to the best of your knowledge.

- | | | | |
|---|-----|----|------------|
| 1. Has anyone in the athlete's family (grandmother, mother, father, brother, sister, aunt, uncle), died suddenly before age 50? | Yes | No | Don't Know |
| 2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? | Yes | No | Don't Know |
| 3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? | Yes | No | Don't Know |
| 4. Has the athlete ever had a bone broken, had to wear a cast, or had an injury to any joint? | Yes | No | Don't Know |
| 5. Does the athlete have a history of a concussion (being knocked out)? | Yes | No | Don't Know |
| 6. Has the athlete ever suffered a heat-related illness (heat stroke)? | Yes | No | Don't Know |
| 7. Does the athlete have anything he/she wants to talk to the doctor about? | Yes | No | Don't Know |
| 8. Does the athlete have a chronic illness or see a doctor regularly for any particularly problem? | Yes | No | Don't Know |
| 9. Does the athlete take any medicine? | Yes | No | Don't Know |
| 10. Is the athlete allergic to any medication or bee stings? | Yes | No | Don't Know |
| 11. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)? | Yes | No | Don't Know |

Please explain all "Yes" answers—use the back if necessary.

MEDICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____

	Normal	Abnormal	Description of Abnormals
Musculoskeletal Exam:			
	<input type="checkbox"/>	<input type="checkbox"/>	Knee
	<input type="checkbox"/>	<input type="checkbox"/>	Ankle
	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder
	<input type="checkbox"/>	<input type="checkbox"/>	Other Joints
	<input type="checkbox"/>	<input type="checkbox"/>	Alignment Problems
	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
	<input type="checkbox"/>	<input type="checkbox"/>	Feet
	<input type="checkbox"/>	<input type="checkbox"/>	Estimate of Strength
	<input type="checkbox"/>	<input type="checkbox"/>	Estimate of Flexibility
Eyes:	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia (males):	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular Exam:	<input type="checkbox"/>	<input type="checkbox"/>	
Other Exam (if indicated by history):	<input type="checkbox"/>	<input type="checkbox"/>	

ASSESSMENT: I certify that I have examined this child and find him/her medically:

_____ **QUALIFIED** to participate (no conditions that would prevent this participant from participation)

_____ **NOT QUALIFIED** to participate for the following reasons _____

Licensed to practice medicine in North Carolina? **YES** **NO**

Printed Name of Doctor: _____

Signature of Doctor: _____

Address: _____

Date: _____