

Physical Form (Must be for this Calendar Year, dated after April 1st

Childs Name:	Age:
Date of Birth://	-
Any Known Allergies: Yes/No. If yes, please list allergies	:
Any Known Disabilities: Yes/No. If yes, please list any: _	
Physicians Statement of Health: I certify that I have examined	
And have found no gross evidence of any abnormality tha participating in the Youth Sports Program.	t will keep him/her from
Physicians Name:	
Address: Phone	
Signature: Da	te:
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DR STAMP REQUIRED HERE TO BE VALID