Physical Form

(Must be for the current Calendar Year, dated after April 1st)

Athlete's Name: **Age:**

_____ _____

Date of Birth: _____/_____/_____

Any Known Allergies: Yes / No

If yes, please list allergies: _____

Any Known Disabilities: Yes / No

If yes, please list disabilities: _____

Physician's Statement of Health:

I certify that I have examined _____

I have found no gross evidence of any abnormality that will keep him/her from participating in the Youth Sports Program.

Physicians Printed Name: _____

Address: **Phone:**

_____ _____

Signature: **Date:**

_____ _____

Physical Form

(Must be for the current Calendar Year, dated after April 1st)

DR STAMP REQUIRED HERE TO BE VALID