



SNOOP Youth Football League PHYSICAL EXAM FORM

SNOOP YOUTH FOOTBALL LEAGUE FORM-002

No Candidate Will Be Permitted To Participate In Any Activity Until This Form Has Been Completed In Full!

Association: _____ Date of Physical: _____

Team Chapter: _____ Team Name: _____

Candidate's Name _____ Age _____ D.O.B. ____/____/____

Address _____ City _____ State _____

MEDICAL HISTORY:

Glasses/contacts	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bleeding tendencies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Surgery within past year	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell tendency	<input type="checkbox"/>	<input type="checkbox"/>
History of Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Repeated bone or joint injury	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries within past year	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus(shot date)	<input type="checkbox"/>	<input type="checkbox"/>
Fractures within past year	<input type="checkbox"/>	<input type="checkbox"/>	Kidneys disease/infections	<input type="checkbox"/>	<input type="checkbox"/>	Current Medications	_____	
Dentals braces or dentures	<input type="checkbox"/>	<input type="checkbox"/>	Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	Remarks	_____	

VITALS:
Weight: _____ Height: _____ Pulse: _____ Blood Pressure: _____ Respiration: _____

SYSTEMS REVIEW:

HEART (N) _____ EARS (N) _____
 LUNGS (N) _____ NOSE (N) _____
 ABDOMEN (N) _____ THROAT (N) _____
 EYES (N) _____

HERNIA:

umbilical / Inguinal: _____

POSTURE / RANGE OF MOTION:

Neck Cervical Thoracic / Lumbar: _____
 Tremor Tremorities:
 Upper: _____
 Lower: _____

I hereby certify that I have on this date examined this child and that, on the basis of the physical examination requested and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this child to compete in supervised athletic activities.

Doctors Stamp: _____

Physician's NAME (Printed): _____
 Physician's SIGNATURE: _____
 Physician's PH#: () _____