



**SUPEREME YOUTH FOOTBALL CONFERENCE
PHYSICAL EXAMINATION FORM**



SECTION VI:

This form satisfies Section V of the Player Season Contract. This form **MUST BE COMPLETED BY** a Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), Nurse Practitioner or Physician's Assistant as described in Rules, Article III, Section C, Certification #3.

SYFC CHAPTER: Ruthless Steelers
Inland Empire Buccaneers

DIVISION: 6U 7U 8U 9U 10U 11U 12U 13U 14U

ACTIVITY: CHEER FOOTBALL

CANDIDATE'S NAME: _____ BIRTH DATE: _____ TELEPHONE: _____
(LAST, FIRST, MI) *(BEST CONTACT)*

ADDRESS: _____ CITY: _____, CA ZIP CODE: _____

PHYSICIAN NAME: _____ PHYSICIAN'S TELEPHONE: _____

The candidate mentioned above has my/our permission to participate in SYFC activities and has permission to travel with the SYFC and Local Chapter Associates. In case of an injury, a SYFC or Local Chapter Official is authorized to have him/her treated and/or hospitalized by any doctor or facilities cooperating with SYFC or Local Chapter, and will not hold SYFC or Local Chapter and Associates responsible for payment as a result of any accident or injury.

MEDICAL HISTORY: (TO BE COMPLETED BY PARENT/GUARDIAN)

RIGHT HANDED LEFT HANDED?

ALLERGIES TO MEDICATION: _____

HAS THE CANDIDATE HAD ANY OF THE FOLLOWING:

(PLEASE CHECK ALL BOXES)

IF "YES" PLEASE EXPLAIN

- | | | | |
|---|------------------------------|-----------------------------|-------|
| 1. Injuries to HEAD, NECK, SPINE, or BONES/JOINTS? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| 2. Any other injuries requiring medical attention? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| 3. Seizures, blackouts, or dizziness? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| 4. Heart issues, heart murmur, high blood pressure? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| 5. Any serious infectious diseases? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| 6. Hospitalizations or any surgeries? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| 7. Stomach, intestinal, or urinary tract issues? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| 8. Is the candidate under the care of a doctor currently? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| 9. Are there any medications prescribed for daily use? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| 10. Any dental issues? ----- | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

PHYSICAL EXAMINATION (TO BE COMPLETED BY PHYSICIAN)

DATE OF PHYSICAL: _____

HEIGHT:		HEART:	
WEIGHT:		LUNGS:	
PULSE:		CHEST:	
BLOOD PRESSEURE:		ABDOMEN:	
GENERAL APPERANCE:		BACK & EXTREMITIES:	
HEAD & NECK:		DERMIS:	
NEUROLOGY:		ANY OTHER CONCERNS:	

From the above evaluation and physical exam, in my opinion, the mentioned candidate is physically able to participate in SYFC or Local Chapter activities? YES NO

Is further consultation necessary? YES NO EXPLANATION: _____

DOCTOR'S OFFICE STAMP OR SEAL

PHYSICIAN'S SIGNATURE: _____

DATE: _____

CHAPTER AD OFFICIAL

DATE