Physical Form (Must be for this Calendar Year

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 that will keep him/her from participating in the Youth Sports Program.

Physicians Name:

Address:

Phone

Signature:

Date:

**DR STAMP REQUIRED HERE TO BE VALID**