SOUTHEAST TROJANS YOUTH FOOTBALL & CHEER
PLAYER/CHEERLEADER Sports Physical Form

Name_____ Date of Examination _____

Date of Birth _____ Age _____ Gender circle one M or F

Address_____ Phone_____

Height _____ Weight _____ Pulse _____ BP _____ Pupils _____ _____
Equal Unequal

Vision R20/ _____L20/ _____ Glasses/Contacts circle one Yes No

Parent/Guardian Name _____ Phone _____

MEDICAL HISTORY
Does your child have or has had within the past year (please circle any that applies to your child and explain on the lines provided below).

Head injuries	History of Heart Trouble	Glasses/Contacts
Fracture(s)	Surgery	Asthma
Serious Injuries	Repeated bone/joint trouble	Bleeding tendencies
Seizures (fits)	Diabetes	Allergies

*__Explanation with dates, known allergies, current medication relevance__ _____

_____

MEDICAL	NORMAL	ABNORMAL FINDINGS	MUSCULO-SKELETAL	NORMAL	ABNORMAL FINDINGS
Appearance	_____	_____	Neck	_____	_____
Skin	_____	_____	Back	_____	_____
Eyes/Ear/Nose	_____	_____	Shoulder/Arm	_____	_____
Throat/Oropharynx	_____	_____	Elbow/forearm	_____	_____
Lymph Nodes	_____	_____	Wrist/hand	_____	_____
Heart	_____	_____	Hip/thigh	_____	_____
Pulses	_____	_____	Knee	_____	_____
Lungs	_____	_____	Leg/ankle	_____	_____
Abdomen	_____	_____	Foot	_____	_____
Genitalia/Hernia	_____	_____			

CLEARANCE
[ ] Cleared for Athletics
[ ] Cleared after completing evaluation/rehabilitation for: _____
[ ] Not Cleared for _____ Reason _____
Recommendations
_____
_____
Name of Physician (print/type) _____ Date _____
Address _____ Phone _____
Signature of Physician _____ MD / DO / NP / PA-C
NOTE: This form is NOT valid without the attending Physicians signature, address, and phone number.