



Snoop Youth Football League PHYSICAL EXAM FORM

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:

	Yes	No		Yes	No		Yes	No
Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendencies	<input type="checkbox"/>	<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)	_____	
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:

Cervical Thoracic / Lumbar: _____

Extremities:

Upper: _____

Lower: _____

I certify that I have on this date examined this child and that, on the basis of the 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:

DOCTORS NAME (Printed): _____

DOCTORS SIGNATURE: _____

DOCTORS PH#: (_____) _____