

# BRYAN YOUTH FOOTBALL ASSOCIATION

2019 Physical Examination: This report must be completed by a qualified and licensed Physician

Participant Name \_\_\_\_\_

**To Physician:** Your careful examination and written recommendations will encourage personal fitness and safety participation in strenuous sports activities. Please complete the following physical evaluation and review medical history with subject athlete.

Normal		Abnormal	Explanation If Abnormal	
<input type="checkbox"/>	Weight	_____ lbs.	<input type="checkbox"/>	_____
<input type="checkbox"/>	Eyes		<input type="checkbox"/>	_____
<input type="checkbox"/>	Vision		<input type="checkbox"/>	_____
<input type="checkbox"/>	Ears		<input type="checkbox"/>	_____
<input type="checkbox"/>	Nose		<input type="checkbox"/>	_____
<input type="checkbox"/>	Throat		<input type="checkbox"/>	_____
<input type="checkbox"/>	Lungs		<input type="checkbox"/>	_____
<input type="checkbox"/>	Heart		<input type="checkbox"/>	_____
<input type="checkbox"/>	Blood Pressure	_____	<input type="checkbox"/>	_____
<input type="checkbox"/>	Extremities		<input type="checkbox"/>	_____

## MEDICAL HISTORY

Check any of the following illnesses or symptoms that have occurred to the subject athlete in the past or at the present time.

- |                          |   |                          |               |
|--------------------------|---|--------------------------|---------------|
| <input type="checkbox"/> | Asthma                                    | <input type="checkbox"/> | Fainting      |
| <input type="checkbox"/> | Diabetes                                  | <input type="checkbox"/> | Heart Problem |
| <input type="checkbox"/> | Headaches                                 | <input type="checkbox"/> | Convulsions   |
| <input type="checkbox"/> | Medication Allergies/Reactions (describe) | _____                    |               |
| <input type="checkbox"/> | Surgery (describe)                        | _____                    |               |
| <input type="checkbox"/> | None of the above                         |                          |               |

I certify that I have reviewed the medical history and examined the subject athlete and find him/her physically fit to participate in competitive sports activities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Licensed Practitioner*

## PARENTAL/GUARDIAN MEDICAL TREATMENT AUTHORIZATION

In the event of injury or illness to my/our child, \_\_\_\_\_, I/We hereby grant authority to a qualified physician to render such medical treatment as said physician deems necessary under the circumstances:

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_