# BRYAN YOUTH FOOTBALL ASSOCIATION

2020 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** |
|---|---|---|---|---|
| [ ] | Weight | _____lbs. | [ ] | _____ |
| [ ] | Eyes | | [ ] | _____ |
| [ ] | Vision | | [ ] | _____ |
| [ ] | Ears | | [ ] | _____ |
| [ ] | Nose | | [ ] | _____ |
| [ ] | Throat | | [ ] | _____ |
| [ ] | Lungs | | [ ] | _____ |
| [ ] | Heart | | [ ] | _____ |
| [ ] | Blood Pressure | _____ | [ ] | _____ |
| [ ] | Extremities | | [ ] | _____ |

## 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.

| | | | |
|---|---|---|---|
| [ ] | Asthma | [ ] | Fainting |
| [ ] | Diabetes | [ ] | Heart Problem |
| [ ] | Headaches | [ ] | Convulsions |
| [ ] | Medication Allergies/Reactions (describe) | _____ | |
| [ ] | Surgery (describe) | _____ | |
| [ ] | 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:_____