SUPEREME YOUTH FOOTBALL CONFERENCE
PHYSICAL EXAMINATION FORM

SECTION VI:

This form satisfies Section V of the Player Season Contract. This form **MUST BE COMPLETED BY** a Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), Nurse Practitioner or Physician's Assistant as described in Rules, Article III, Section C, Certification #3.

SYFC CHAPTER: *Inland Empire Buccaneers* **DIVISION:** ☐**6U** ☐**7U** ☐**8U** ☐**9U** ☐**10U** ☐**11U** ☐**12U** ☐**13U** ☐**14U**

ACTIVITY: ☐***CHEER*** ☐***FOOTBALL***

CANDIDATE'S NAME: _____ **BIRTH DATE:** _____ **TELEPHONE:** _____
(LAST, FIRST, MI) ***(BEST CONTACT)***

ADDRESS: _____ **CITY:** _____ ,CA **ZIP CODE:** _____

PHYSICIAN NAME: _____ **PHYSICIAN'S TELEPHONE:** _____

The candidate mentioned above has my/our permission to participate in SYFC activities and has permission to travel with the SYFC and Local Chapter Associates. In case of an injury, a SYFC or Local Chapter Offical is authorized to have him/her treated and/or hospitalized by any doctor or facilities cooperating with SYFC or Local Chapter, and will not hold SYFC or Local Chapter and Associates responisble for payment as a result of any accident or injury.

MEDICAL HISTORY: (*TO BE COMPLETED BY PARENT/GUARDIAN*)

☐ RIGHT HANDED ☐ LEFT HANDED? **ALLERGIES TO MEDICATION:** _____

HAS THE CANDIDATE HAD ANY OF THE FOLLOWING:	(***PLEASE CHECK ALL BOXES***)		**IF "*YES*" PLEASE EXPLAIN**
1. Injuries to HEAD, NECK, SPINE, or BONES/JOINTS?	☐ **YES**	☐ **NO**	
2. Any other injuries requiring medical attention?	☐ **YES**	☐ **NO**	
3. Seizures, blackouts, or dizziness?	☐ **YES**	☐ **NO**	
4. Heart issues, heart murmur, high blood pressure?	☐ **YES**	☐ **NO**	
5. Any serious infectious diseases?	☐ **YES**	☐ **NO**	
6. Hospitalizations or any surgeries?	☐ **YES**	☐ **NO**	
7. Stomach, intestinal, or urinary tract issues?	☐ **YES**	☐ **NO**	
8. Is the candidate under the care of a doctor currently?	☐ **YES**	☐ **NO**	
9. Are there any medications prescribed for daily use?	☐ **YES**	☐ **NO**	
10. Any dental issues?	☐ **YES**	☐ **NO**	

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PHYSICAL EXAMINATION (*TO BE COMPLETED BY PHYSICIAN*) **DATE OF PHYSICAL:** _____

HEIGHT:		**HEART:**	
WEIGHT:		**LUNGS:**	
PULSE:		**CHEST:**	
BLOOD PRESSEURE:		**ABDOMEN:**	
GENERAL APPERANCE:		**BACK & EXTREMITIES:**	
HEAD & NECK:		**DERMIS:**	
NEUROLOGY:		**ANY OTHER CONCERNS:**	

From the above evaluation and physical exam, in my opinion, the mentioned candidate is physically able to participate in SYFC or Local Chapter activities? ☐**YES** ☐**NO**

Is further consultation necessary? ☐**YES** ☐**NO** **EXPLANATION:** _____

DOCTOR'S OFFICE STAMP OR SEAL

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

_____ _____
CHAPTER AD OFFICAL **DATE**