

**COMMUNITY YOUTH FOOTBALL LEAGUE, INC.  
Physical Form**

<b>Patient's Name:</b>					<b>Age:</b>				
<b>Athlete's Directions:</b>		<b>Please review all questions with your parents or guardian and answer them to the best of your knowledge.</b>							
<b>Physician's Directions:</b>		<b>We recommend repeating the 11 questions listed below and carefully reviewing details of any positive answers.</b>							
<b>Question</b>		<b>YES</b>	<b>NO</b>	<b>Don't Know</b>					
1. Has anyone in the athlete's family (grandparents, siblings, aunt or uncle died suddenly before the age of 60 years?)									
2. Has the athlete ever passed out during exercise or stopped exercising because of dizziness?									
3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercising?									
4. Has the athlete ever broken a bone, had to wear a cast, or had an injury to any joint?									
5. Does the athlete have a history of concussion (getting knocked out)?									
6. Has the athlete ever suffered a heat related illness (heat stroke)?									
7. Does the athlete have anything he or she wants to discuss with the Physician?									
8. Does the athlete have a chronic illness or see a Physician regularly for any particular problem?									
9. Does the athlete take any medications?									
10. Is the athlete allergic to any medication?									
11. Does the athlete have only one of any paired organs (eyes, kidneys, testicles, ovaries, etc)?									
Please elaborate on positive answers									
<p>I have answered and reviewed the questions above and give my permission for my child to participate in sports.</p>									
_____				_____					
Signature Parent/Guardian				Date					
<b>Physical Information</b>									
<b>ALL PLAYERS AND CHEERLEADERS MUST HAVE A PHYSICAL EXAM ONE YEAR PRIOR TO PARTICIPATING DURING THE SEASON. THIS FORM MUST BE COMPLETED AND RETURNED.</b>									
Height		Weight		Lungs		Eyes		Feet	
Nose		Abdomen		Extremities		Blood Pressure	/		
Throat		Hernia		Heart		Teeth		Ears	
Skin		Urine		Physician's Comments:					
_____					_____				
Signature of Physician or Examiner					Date				