



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 Official 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 responsible 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 OFFICIAL

DATE