

GOLDEN LEAGUE YOUTH FOOTBALL CONFERENCE, INC.
FOOTBALL/CHEERLEADING
PHYSICAL EXAM FORM - 2006

Association: _____ **Date of Physical:** _____

Participant's Name: _____ **Age** _____ **D.O.B.** _____

Division of Play: _____ **Circle One: Football or Cheerleading**

MEDICAL HISTORY:

	Yes	No		Yes	No		Yes	No	Tetanus (shot date)
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries within past year	<input type="checkbox"/>	<input type="checkbox"/>	Surgery within past year	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	History of heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Current Medications
Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Repeated bone or joint injuries	<input type="checkbox"/>	<input type="checkbox"/>	Kidney diseases/infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fractures within past year	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental braces or bridges	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Tendency	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Remarks

VITALS:

Blood Pressure _____ **Respiration** _____

Weight _____ **Height** _____ **Pulse** _____ **Temperature** _____

SYSTEMS REVIEW:

HEART (N) _____ **EARS (N)** _____

LUNGS (N) _____ **NOSE (N)** _____

ABDOMEN (N) _____ **THROAT (N)** _____

EYES (N) _____

HERNIA:

Umbilical / Inguinal: _____

POSTURE / RANGE OF MOTION:

Cervical Thoraco / Lumbar: _____

Extremities:

Upper: _____

Lower: _____

DOCTORS NAME (Printed): _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DOCTORS SIGNATURE: _____