



Physical Form (Must be for this Calendar Year)

Childs Name: _____ Age: _____

Date of Birth: ____/____/____

Any Known Allergies: Yes/No. If yes, please list allergies: _____

Any Known Disabilities: Yes/No. If yes, please list any: _____

Physicians Statement of Health:

I certify that I have examined _____

And have found no gross evidence of any abnormality that will keep him/her from participating in the Youth Sports Program.

Physicians Name: _____

Address: _____ Phone _____

Signature: _____ Date: _____

DR STAMP REQUIRED HERE TO BE VALID