MOTHERLODE VALLEY YOUTH FOOTBALL LEAGUE

Derived from The American Academy of Family Physicians
Athletic Competition Health Screening Form

PLAYER/CHEERLEADER

LAST NAME	FIRST NAME	AGE
ELEMENTARY SCHOOL ATTENDING	DATE OF BIRTH	SEX

PARENT/GUARDIAN (to be completed by parent/guardian)
NAME
ADDRESS
PHONE

PHYSICIAN/PROVIDER STAMP (to be completed by physician/medical provider)

Answer Yes or No Only	Yes	No
Chronic/Recurrent Illness?		
Hospitalization?		
Surgery other than tonsils?		
Injuries treated by physician?		
Current Medications?		
Organs missing?		
Heat exhaustion/stroke?		
Dizziness, fainting, convulsions and or/headaches?		
Knocked out?		
Concussion?		
Wear glasses or contacts?		
Hearing defects?		
Dental appliances-bridge, braces, cap, plate?		
Cough/pain?		
Problems with blood pressure, heart /murmurs?		
Hernia?		
Recurrent skin disease?		
Bone/joint injury?		
Sprain/Dislocation?		
Injury that caused a missed practice or event?		
Allergies?		
Allergies to medications?		
Other Allergies?		
Tetanus booster in last 10 years?		

Vital Signs	SATISFACTORY Yes	SATISFACTORY No	Physical Evaluation Comments	Recommended Follow Up
Height				
Weight				
BP				
General				
Head				
Eyes			Acuity: L R	
ENT				
Dental				
Chest				
Heart				
Abdomen				
Genitalia				
Skin				
Extremities Back/Neck				

THE INFORMATION PROVIDED ABOVE IS CURRENT AND TRUE TO THE BEST OF MY KNOWLEDGE

SPORTS PARTICIPATION APPROVED: YES NO

LIMITATIONS: _____

CONCERNS: _____

PARENT/GUARDIAN SIGNATURE	DATE	PHYSICIAN/PROVIDER SIGNATURE	DATE