



**Physical Form** (Must be for this Calendar Year, dated after April 1st

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: \_\_\_\_\_



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**DR STAMP REQUIRED HERE TO BE VALID**