UNITED STATES FOOTBALL LITTLE LEAGUE

Physical Form

Doctor's Name: _____ Phone: _____

Address: _____
Street City State Zip

Allergies: _____

Name: _____ Date of Birth: ___/___/_____
Father's Name: _____ Daytime phone, pager, cell phone: _____
Mother's Name: _____ Daytime, phone, pager, cell phone: _____
Street address: _____
City: _____Zip Code: _____ Home phone: _____

Alternate Emergency Contact Person: _____ Daytime phone: _____
Please indicate MEDICAL ALERTS such as allergic reactions, contact lenses, etc.: _____
_____

PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Vision: R _____ / _____ uncorrected R _____ / _____ corrected L _____ / _____ uncorrected L _____ / _____ corrected

	Normal	Abnormal Findings	Initials
1. Eyes			
2. Ears, Nose, Throat			
3. Mouth & Teeth			
4. Neck			
5. Cardiovascular			
6. Chest & Lungs			
7. Abdomen			
8. Skin			
9. Genitalia-Hernia (male)			
10. Muskuloskeletal: ROM, strength, etc.			
a. neck			
b. spine			
c. shoulders			
d. arms/ hands			
e. hips			
f. thighs			
g. knees			
h. ankles			
i. feet			
11. Neuromuscular			

Please Print/ Stamp

Physician's Name _____
Street Address _____
City, State, Zip Code _____
Telephone _____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature _____ Date _____

PARTICIPATION RESTRICTIONS:

_____
_____
_____