



THE VALLEY YOUTH ATHLETIC ASSOCIATION, INC - MEDICAL EXAMINERS REPORT

Statement to the Physician

The below named individual has applied to participate in The Valley Conference Tackle Football, Cheerleading, Basketball, or Track Program. These are highly competitive and physically demanding programs.

A physical examination is required prior to participation in these programs. Please comment on any significant history or abnormal physical findings on back of this form.

PRINT FULL NAME AND DATE OF BIRTH

_____ Last Name _____ First Name _____ Middle Name _____ Month _____ Day _____ Year _____

History (to be completed by parent/guardian)

Does the athlete have to any significant degree any of the following?

Yes No

Weight _____ Lbs

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Trouble with vision or hearing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Any history of lung disease such as asthma?
Wheezing? Chronic cough? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Any history of heart trouble a) Rheumatic fever,
b) heart murmur, c) palpitation or irregular heart rate,
d) enlarged heart | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Any history of stomach, intestinal or liver trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Any history of kidney trouble such as glomerulonephritis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Any bone, muscular or neurological disease? | <input type="checkbox"/> | <input type="checkbox"/> |

Signature _____

Parent/Guardian

Physician: is the athlete able to participate in full activities?

If so describe _____

Should there be any limitations? _____

Physical Examination

Pulse _____ Blood Pressure _____

On examination is there any abnormality of any of the following?

If so please explain.

	Normal	Abnormal	Explanation
Eyes.....			
Ears.....			
Nose.....			
Throat.....			
Neck.....			
Lungs.....			
Heart.....			
Abdomen.....			
Back.....			
Hernia.....			
Neurological..			
Skin.....			
Skeletal.....			

MD Medical Examiner's Signature

Date

Physician Stamp Required

NOTICE

Registered Nurses or Nurse Practitioners **MAY NOT** perform any physical and sign the medical examination report form.

Physical Examination form must be signed dated and stamp by a MD Physician