This form is to be filled out completely and turned in to SFYFC Administration before applicant can participate in any practices, games, etc.

2024 Southeast Falcons Youth Football - Physical Form

_____ _____/_____/_____

PARTICIPANTS' NAME Date of Birth (MMDDYY)

As parent or legal guardian of Participant, I hereby ***give my consent*** for his/her participation in the athletic events listed above.

I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand every effort will be made to contact me prior to treatment. I agree to the need for screening medical examination and certify that the medical history is accurate to the best of my knowledge. I also understand this examination is a limited medical checkup to screen your child to see if he/she can safely participate in sports. The exam does screen for the common problems that have been shown to be a danger to athletes. It is not a comprehensive medical exam and often does not detect rare medical conditions. If you have concerns about your child having a serious medical illness, please schedule a visit with your personal physician.

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

PRIMARY CARE PHYSICIAN_____PHONE_____

INSURANCE PROVIDER _____POLICY #_____PHONE_____

MEDICAL HISTORY

Please review all questions answer them to the best of your knowledge:

1. Has anyone in the athlete's family (grandmother, mother, father, brother, sister, aunt, uncle), died suddenly before age 50? **Yes No Don't Know**

2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? **Yes No Don't Know**

3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? **Yes No Don't Know**

4. Has the athlete ever had a bone broken, had to wear a cast, or had an injury to any joint? **Yes No Don't Know**

5. Does the athlete have a history of a concussion (being knocked out)? **Yes No Don't Know**

6. Has the athlete ever suffered a heat-related illness (heat stroke)? **Yes No Don't Know**

7. Does the athlete have anything he/she wants to talk to the doctor about? **Yes No Don't Know**

8. Does the athlete have a chronic illness or see a doctor regularly for any particularly problem? **Yes No Don't Know**

9. Does the athlete take any medicine? **Yes No Don't Know**

10. Is the athlete allergic to any medication or bee stings? **Yes No Don't Know**

11. Does the athlete have only one of a paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)? **Yes No Don't Know**

12. Any medical conditions, behaviors or other special needs you feel we should know about the athlete? Such as emotional issues or outbursts; ADD/ADHD; Autism Spectrum disorder; other? **Yes No**

13. Does the athlete wear corrective lenses/glasses? **Yes No** All of the time Just to read

Please explain all "Yes" answers*—use the back if necessary.*

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MEDICAL EXAMINATION Height: _____ Weight: _____ Blood Pressure: _____

	Circle One:	**Description of Abnormal:**
Musculoskeletal Exam	Normal / Abnormal	
Knee	Normal / Abnormal	
Ankle	Normal / Abnormal	
Shoulder	Normal / Abnormal	
Other Joints	Normal / Abnormal	
Alignment Problems	Normal / Abnormal	
Scoliosis	Normal / Abnormal	
Feet	Normal / Abnormal	

	Circle One:	Description of Abnormal:
Estimate of Strength	Normal / Abnormal	
Estimate of Flexibility	Normal / Abnormal	
Eyes	Normal / Abnormal	
Genitalia (males)	Normal / Abnormal	
Cardiovascular Exam	Normal / Abnormal	

Other Exam (if indicated by history): Normal / Abnormal

ASSESSMENT: I certify that I have examined this child and find him/her medically:

_____**QUALIFIED to participate (no conditions that would prevent this participant from participation)**

_____**NOT QUALIFIED to participate for the following reasons:**

_____

_____**Other/Recommendations**_____

I certify that I am Licensed to practice medicine in North Carolina? **YES** **NO**

_____

Printed Name of Doctor | Signature of Doctor | Date

_____

Facility Name / Address