NEVADA YOUTH SPORTS
MIDDLE SCHOOL FOOTBALL LEAGUE PHYSICAL FORM

PART 1: Identifying Data (to be completed for Athlete by parent/guardian)

Name: _____ Student #: _____ Grade: _____

Address: _____ City _____ ZIP _____

Phone: (H): _____ (W) _____

Birth date: _____ Age: _____ Sex (circle): M F

Health Insurance Carrier (primary): _____

HEALTHY HISTORY (must be completed prior to examination)

Has this Athlete had any:

YES	NO	
		Chronic or recurring illness
		Illness lasting over 1 week
		Hospitalizations
		Surgery other than removal of tonsils
		Missing organs (eye, kidney, testicale)
		Allergies (medicines, insect bites, food)
		Problems with heart or blood pressure
		Chest pain or severe shortness of breath with exercise

Is there any history of:

YES	NO	
		Injuries requiring physician treatment
		Neck or back injury
		Knee injury
		Shoulder or elbow injury
		Ankle injury
		Other serious joint injury
		Broken bones (fractures)

Further History:

		Dizziness or fainting with exercise
		Fainting bad headaches or convulsions when participating in sports
		Concussion or loss of consciousness
		Any reason why Athlete should not
		Has family member died suddenly

Does this Athlete:

		Wear eye glasses or contact lenses
		Wear dental bridges, braces or plates
		Take any medications. Please list them: _____

Date of last known tetanus (lockjaw) shot: _____

Parent's or Guardian's Acknowledgement:

I have reviewed and agree with the above information. I also understand that this examination is primarily for sports participation screening and is not intended to replace the routine healthcare visits as recommended by the student's personal physician. I know of no reason why the above named student should not participate in the SOUTHERN NEVADA YOUTH SPORTS ASSOCIATIONS MIDDLE SCHOOL FOOTBALL LEAGUE in supervised tackle football activities.

_____ _____

Print Name of Parent/Guardian Signature of Parent Guardian

Work Phone: _____ Date: _____

ATHLETIC PRE-PARTICIPATION SCREENING EXAM Student:

PART 2: General Examination (to be completed by the examining Physician)

Pulse: _____ BP: _____ Height: _____ Weight: _____

Visual Acuity: _____

PHYSICIAN RECOMMENDATIONS:

	Unlimited Participation
	Clearance withheld pending further evaluation (Comment)
	Participation limited to specific sports (Comment)
	No athletic participation

Doctor's Signature: _____ Date: _____

Please print or use an office stamp:

Doctor's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____