



Arkansas City Youth Football Physical Form

Not for middle school or high school athletics

Parent / Guardian Name: _____ Phone: _____

Address: _____ Email: _____

Athlete History (To be completed by parent / guardian on behalf of student athlete)

Student Name: _____ Date of Birth: _____

School _____ City: _____

Male / Female _____ Grade in School _____

Please answer the following questions:	YES	NO
Have any members of your family under age 50 had a heart attack or heart problems?		
Have you ever been told you have a heart murmur, high blood pressure, extra heart beats or heart abnormality?		
Do you ever have to stop while running ½ mile because of shortness of breath or severe chest pain?		
Are you taking any medications?		
Have you passed out or been knocked unconscious?		
Have you had any illness or injury that required emergency medical or surgical attention or lasted longer than one week?		
Have you had any illness or injury that caused you to miss practices or games?		
Have you had any illness or injury that was related to insect sting, medication or food?		

These answers are correct to the best of my knowledge: _____

Parent / Guardian Signature

Athlete Physical Examination (Items to be completed by Physician)

Height: _____ Weight: _____ Age: _____	Chest / Heart: _____ PMI _____ Rhythm _____ Murmurs _____ Lungs _____
Blood Pressure: _____ Pulse: _____	Lymphatic: _____
Hearing (passed screening) yes _____ no _____ date _____	Abdomen: _____
Vision L20/ _____ R20/ _____ with RX _____ without RX _____ date _____	Genitalia Hernia: _____
Diphtheria / tetanus immunization _____ recent date: _____	Maturation Index: (Tanner Stage) _____
Please check / comment if abnormal	Orthopedic: Cervical _____ Back _____ Spine _____ Shoulders _____ Arm _____ Elbow _____ Wrist _____ Hip _____ Knee _____ Ankle _____
Skin: _____ Mouth / Dental: _____	
Eyes: _____ Pupil size: equal _____ unequal _____	
Comments: _____	Comments: _____

Disposition: Full participation _____ Further evaluation (comments) _____

Limited participation (comments) _____

NO Participation (comments) _____

PHY

I certify I am qualified to perform examination: Physician's Signature

Date physical performed