**SOUTHERN CALIFORNIA KING CONFERENCE YOUTH FOOTBALL LEAGUE AND CHEER CONFERENCE**

PHYSICAL EXAMINATION FORM

ORIGINAL AND TWO COPIES ARE REQUIRED TO COMPLETE YOUR REGISTRATION

***REVISED 2019***

ASSOCIATION NAME: _____ DIVISION: 6U 8U 9U 10U 11U 12U 13U 14U CHEER
(CIRCLE ONE)

ATHLETE'S NAME: _____ BIRTHDATE: _____ PHONE: _____
(Last Name, First Name, MI)

ADDRESS: _____ _____ , CA _____
(Street) (City) (Zip)

PHYSICIAN NAME: _____ PHYSICIAN PHONE: _____

The above named athlete has my permission to participate in SOUTHERN CALIFORNIA KING CONFERENCE YOUTH FOOTBALL AND CHEER (SCKCFL) activities and has permission to travel with a representative of SCKCFL and the local Association on any trips. In case of injury a SCKCFL representative is authorized to have him/her treated and/or hospitalized by any one of the doctors cooperating with SCKCFL, and will not hold SCKCFL, the local Association or its representatives responsible for payment as the result of any accident or injury.

**MEDICAL HISTORY (to be completed by parent/guardian)**

R or L Handed: _____ Allergies to Medications: _____

| Has athlete had the following: | ALL boxes must be checked | | Explain "Yes" Answers |
|---|---|---|---|
| 1. Injuries to head, neck, bones or joints | ☐ YES | ☐ NO | _____ |
| 2. Any other injuries requiring medical attention | ☐ YES | ☐ NO | _____ |
| 3. Seizures, blackouts or any episode of unconsciousness | ☐ YES | ☐ NO | _____ |
| 4. Heart trouble, heart murmur, high blood pressure | ☐ YES | ☐ NO | _____ |
| 5. Any serious infectious disease | ☐ YES | ☐ NO | _____ |
| 6. Hospitalization or operations in the past | ☐ YES | ☐ NO | _____ |
| 7. Stomach, intestinal or urinary tract problems | ☐ YES | ☐ NO | _____ |
| 8. Is athlete under care of a doctor now | ☐ YES | ☐ NO | _____ |
| 9. Is athlete taking any medication on a regular basis | ☐ YES | ☐ NO | _____ |
| 10. Any dental problems? | ☐ YES | ☐ NO | _____ |

Parent or Legal Guardian Signature: _____ Date: _____

**PHYSICAL EXAMINATION (to be completed by physician)**

DATE OF PHYSICAL: _____

| Physical Exam | | | | | |
|---|---|---|---|---|---|
| HEIGHT: | | WEIGHT: | | HEART: | |
| BLOOD PRESSURE: | | | | LUNGS: | |
| PULSE: | | | | CHEST (including Breasts) | |
| GENERAL APPEARANCE: | | | | ABDOMEN: | |
| DERM: | | | | BACK & EXTREMITIES: | |
| HEAD: | | | | NEUROLOGICAL: | |
| NECK: | | | | | |

From the above information and the screening physical exam, in my opinion, the above mentioned Athlete is physically able to participate in SCKCFL activities? ☐ YES ☐ NO

Is further consultation necessary? Specialty: _____ ☐ YES ☐ NO

Doctor Office Seal or Stamp Here

Physician's Signature: _____ M.D. Date: _____