KEYSTONE YOUTH FOOTBALL LEAGUE

MEDICAL FORM

MUST BE COMPLETED BY PHYSICIAN BEFORE YOUR CHILD MAY PARTICIPATE IN PRACTICES OR GAMES

Child's Name: _____

Address: _____

Parent or Legal Guardian: _____

Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Emergency Contact Phone: _____
(If parents or guardian are unavailable)

HOSPITAL TREATMENT AUTHORIZATION

I, the undersigned, being the parent or legal guardian, hereby designate the _____, coaches and/or designee, to authorize any necessary medical and/or surgical treatment needed for the above named child in my absence.

_____ _____
Signature of Parent or Legal Guardian **Date**

THIS MUST BE SIGNED FOR YOUR CHILD TO PARTICIPATE

Preparticipation Physical Evaluation

Physical Examination:

Name_____ Date of Birth _____

Height_____ Weight___ % Body fat (Optional)____ Pulse____ BP ___/___(___/___,___/___)

Vision R20/_____ Corrected: Y N Pupils: Equal_____ Unequal_____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

CLEARANCE

_ Cleared

_ Cleared after completing evaluation/rehabilitation for: _____

_____

_____

_ Not cleared for:_____ Reason:_____

Recommendations:_____

_____

_____

Name of physician

(print/type)_____Date_____

Address_____ Phone_____

Signature of physician_____, MD or DO

Preparticipation Physical Evaluation

HISTORY DATE of EXAM _____

Name _____ **Sex**_____ **Age** _____ **Date of birth** _____
Grade _____ **School** _____ **Sport(s)** _____
Address _____ **Phone** _____
Personal Physician _____
In case of emergency, contact:
Name _____ **Relationship** _____ **Phone (H)** _____ **(W)** _____

Explain "Yes" answers below. Circle questions you don't know the answers to.	**Yes**	**No**
1. Have you had a medical illness or injury since your last sports physical?	_	_
Do you have an ongoing or chronic illness?	_	_
2. Have you ever been hospitalized overnight? Have you ever had surgery?	_	_
	_	_
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	_	_
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	_	_
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	_	_
Have you ever had a rash or hives develop during or after exercise?	_	_
5. Have you ever passed out during or after exercise?	_	_
Have you ever been dizzy during or after exercise?	_	_
Have you ever had chest pain during or after exercise?	_	_
Do you get tired more quickly than your friends do during exercise?	_	_
Have you ever had racing of your heart or skipped heartbeats?	_	_
Have you had high blood pressure or high cholesterol?	_	_
Have you ever been told you have a heart murmur?	_	_
Has any family member or relative died of heart problems or of sudden death before age 50? Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? Has a physician ever denied or restricted your participation in sports for any heart problems?	_	_
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	_	_
7. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost your memory?	_	_
Have you ever had a seizure?	_	_
Do you have frequent or severe headaches?	_	_
Have you ever had numbness or tingling in your arms, hands, legs, or feet?	_	_
Have you ever had a stinger, burner, or pinched nerve?	_	_
8. Have you ever become ill from exercising in the heat?	_	_
9. Do you cough, wheeze, or have trouble breathing during or after activity?	_	_
Do you have asthma?	_	_
Do you have seasonal allergies that require medical treatment?		

	Yes	**No**
10. Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	_	_
11. Have you had any problems with your eyes or vision?	_	_
Do you wear glasses, contacts, or protective eyewear?	_	_
12. Have you ever had a sprain, strain or swelling after an injury?	_	_
Have you broken or fractured any bones or dislocated any joints?	_	_
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	_	_
If yes, check appropriate box & explain below:		
_ Head _ Elbow _ Hip		
_ Neck _ Forearm _ Thigh		
_ Back _ Wrist _ Knee		
_ Chest _ Hand _ Shin/calf		
_ Shoulder _ Finger _ Ankle		
_ Upper arm _ Foot		
13. Do you want to weigh more or less than you do now?	_	_
Do you lose weight regularly to meet weight requirements for your sport?	_	_
14. Do you feel stressed out?	_	_
15. Record the dates of your most recent immunizations (shots) for:	_	_
Tetanus_____ Measles_____		
Hepatitis B _____ Chickenpox _____		
FEMALES ONLY		
16. When was your first menstrual period?_____		
When was your most recent menstrual period?_____		
How much time do you usually have from the start of one period to the start of another?_____ How many periods have you had in the last year? _____		
What was the longest time between periods in the last year? _____		
Explain "Yes" answers here:_____		

Athletes Name: **Date:**
Parent/Guardian's Name: **Parent/Guardian's Home Address:**

MEDICAL HISTORY

List all medications you take and the reason you take them:

1.
2.
3.
4.
5.
6.

List any drugs, food, or airborne allergies you have:

1.
2.
3.
4.
5.
6.

List any Surgeries or Hospitalizations you have had:

1.
2.
3.
4.
5.
6.

List whether you wear corrective lenses, contacts, braces, retainers, or other appliances:

1.
2.
3.
4.