

2009 NBYS, INC MEDICAL FORM
TO BE COMPLETED BY LICENSED PHYSICIAN ONLY
PHYSICAL DATED NEEDS TO BE DATED WITHIN A MONTH OF REGISTRATION

Player's Name: _____

Code: S= Satisfactory; X= Not Satisfactory (Explain); O= Not Examined

Weight _____ lbs	Height _____	Blood Pressure _____	Ears _____
Vision _____	Hearing _____	Abdomen _____	Heart _____
Lungs _____	Urinalysis _____	Extremities _____	Hernia _____
Feet _____	Genitalia _____	Throat _____	Nose _____
Teeth _____	Skin _____	Hgb. Test _____	
Posture & Spine _____			

Tuberculosis Test Results _____ Negative _____ Positive
Comments: _____

Asthmatic: Yes No
If yes, please specify what type of medication: _____

Allergy: Yes No
If yes, please specify what type of food or medicine: _____

Describe abnormal findings and/or medical conditions (mental or physical) which may modify activity:

Is this child on any medication? Yes No
If yes, please specify what type of medication: _____

Are there activities you would recommend be restricted? Yes No
If yes, please specify _____

I have examined the person herein described, reviewed his/her healthy history and it is my opinion that he/she is physically able to engage in the Football/Cheerleading activities, except as noted above.

PHYSICIAN'S NAME (PLEASE PRINT)

Telephone () _____

Date of Exam _____ / _____ / _____

PHYSICIAN'S SIGNATURE

Address: _____

PHYSICIAN'S STAMP