Physical Form (Must be for this Calendar Year, dated after April 1st

Childs Name: _____ Age:_____

Date of Birth: ___/___/___

Any Known Allergies: Yes/No. If yes, please list allergies: _____

Any Known Disabilities: Yes/No. If yes, please list any: _____

Physician's Statement of Health:

I certify that I have examined _____

and have found no gross evidence of any abnormality that will keep him/her from participating in the Youth Sports Program.

Physicians Name: _____

Address: _____ Phone: _____

Signature:_____ Date: _____

Physical Form (Must be for this Calendar Year, dated after April 1st

DR STAMP REQUIRED HERE TO BE VALID