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: _____

Physicians 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