



P.O. BOX 443  
PLEASANTON, CA 94566

## CONTACT FOOTBALL PHYSICAL EXAMINATION FORM

**PLEASE COMPLETE THE FOLLOWING:**

1. Name of Player: \_\_\_\_\_

2. Please indicate whether your child has any medical conditions of which the League should be aware (e.g. allergies, asthma, medication, etc.):

\_\_\_\_\_  
\_\_\_\_\_

**PARENT SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

=====

**TO BE COMPLETED BY PHYSICIAN:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Ears \_\_\_\_\_

Eyes \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_ Heart \_\_\_\_\_

Lungs \_\_\_\_\_ Hernia \_\_\_\_\_ Abdomen \_\_\_\_\_

\_\_\_\_\_ Player MAY participate in contact football.

\_\_\_\_\_ Player IS UNABLE to participate in contact football.

**PHYSICIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_