



PLAYER/CHEERLEADER

| | | |
|-----------------------------|---------------|-----|
| LAST NAME | FIRST NAME | AGE |
| ELEMENTARY SCHOOL ATTENDING | DATE OF BIRTH | SEX |

PARENT/GUARDIAN (To Be Completed By Parent/Guardian)

| |
|---------|
| NAME |
| ADDRESS |
| PHONE |

PHYSICIAN (To Be Completed By Physician)

| |
|---------|
| NAME |
| ADDRESS |
| PHONE |

| Answer Yes or No Only | Yes | No |
|--|-----|----|
| Chronic/Recurrent Illness? | | |
| Hospitalization? | | |
| Surgery other than tonsils? | | |
| Injuries treated by physician? | | |
| Current medications? | | |
| Organs missing? | | |
| Heat exhaustion/stroke? | | |
| Dizziness, fainting, convulsions and/or headaches? | | |
| Knocked out? | | |
| Concussion? | | |
| Wear glasses or contacts? | | |
| Hearing defects? | | |
| Dental appliances-bridge, braces, cap, plate? | | |
| Cough/pain? | | |
| Problems with blood pressure, heart or murmurs? | | |
| Problems with liver, spleen or kidney? | | |
| Hernia? | | |
| Recurrent skin disease? | | |
| Bone/joint injury? | | |
| Sprain/dislocation? | | |
| Injury that caused a missed practice or event? | | |
| Allergies? | | |
| Allergies to medications? | | |
| Other allergies? | | |
| Tetanus booster in last 10 years? | | |

**THE INFORMATION PROVIDED ABOVE IS CURRENT
AND TRUE TO THE BEST OF MY KNOWLEDGE**

| Vitals | SATISFACTORY | | Physical Evaluation Comments | Recommended Follow Up |
|-------------|--------------|----|---------------------------------|--------------------------|
| | Yes | No | | |
| Height | | | | |
| Weight | | | | |
| BP: _____ | | | | |
| General | | | | |
| Head | | | | |
| Eyes | | | Acuity: L R | |
| Ent | | | | |
| Dental | | | | |
| Chest | | | | |
| Heart | | | | |
| Abdomen | | | | |
| Genitalia | | | | |
| Skin | | | | |
| Extremities | | | | |
| Back/Neck | | | | |

SPORT PARTICIPATION APPROVED: Yes No

Limitations: _____

Comments: _____

PARENT/GUARDIAN SIGNATURE DATE

PHYSICIAN SIGNATURE DATE