



# Pacific Coast Youth Football/Cheerleading Conference, Inc.

## PHYSICAL EXAM FORM

Revised 03/15/16

This form must be completed and the original copy submitted to the PCC Conference at certification

**Association:** \_\_\_\_\_ **Date of Physical:** \_\_\_\_\_

**Candidate's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_

**Division of Play:** \_\_\_\_\_ **Team Name/Mascot:** \_\_\_\_\_

**MEDICAL HISTORY: (Must be completed by parent prior to examination)**

	Yes	No		Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries within past year	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/Contact	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Dental braces or bridges	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Tendency	<input type="checkbox"/>	<input type="checkbox"/>	History of heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Repeated bone or joint injuries	<input type="checkbox"/>	<input type="checkbox"/>	Surgery within past year	<input type="checkbox"/>	<input type="checkbox"/>	Kidney diseases/infections	<input type="checkbox"/>	<input type="checkbox"/>
Fractures within past year	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus (shot date if known) _____			Any Current Medications: <input type="checkbox"/> <input type="checkbox"/> List: _____					

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**\* The Section Below MUST Be Completed By A Licensed Medical Doctor (MD) or Nurse Practitioner (NP) or Physician Assistant (PA):**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_

	NORMAL		NORMAL
1. EYES		10. MUSCULOSKELETAL, ROM, STRENGTH	
2. EARS, NOSE, THROAT		NECK	
3. MOUTH AND TEETH		SPINE	
4. NECK		SHOULDERS	
5. CARDIOVASCULAR		ARMS/HANDS	
6. CHEST AND LUNGS		HIPS	
7. ABDOMEN		THIGHS	
8. NEUROMUSCULAR		KNEES	
		ANKLES	
9. GENITALIA-HERNIA (Male)		FEET	

ABNORMAL FINDINGS If any:	
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**If Cleared to participate check ONE appropriate category of play: (MD, NP, or PA ONLY)**

( ) **Flag** Football    ( ) **TACKLE** Football    ( ) **Cheerleading w/ Stunting**    ( ) **Cheerleading w/o Stunting**

Restrictions if any:	
( ) <b>NOT CLEARED</b> to Participate in sport	( ) Refer to Family Physician For Clearance

I, hereby my signature below, do certify that I am licensed by the state and am qualified in determining that: **(Childs Name):** \_\_\_\_\_ is physically fit and I have found no medical or observable conditions which would contraindicate him/her from participating in youth flag football, tackle football, cheer, dance, step or athletic activities. I am therefore clearing this individual for athletic participation.

**DOCTORS NAME (Printed):** \_\_\_\_\_  
(MD, NP, or PA)

**DOCTORS SIGNATURE:** \_\_\_\_\_

Doctors Stamp:

  
  

License #: \_\_\_\_\_