Pacific Coast Youth Football/Cheerleading Conference, Inc.

PHYSICAL EXAM FORM

Revised 1/12

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	☐	☐	Head injuries within past year	☐	☐	Palpitations	☐	☐
Allergies	☐	☐	Serious Illness	☐	☐	Chest Pains	☐	☐
Glasses/Contact	☐	☐	Bleeding tendencies	☐	☐	Dizziness	☐	☐
Dental braces or bridges	☐	☐	Sickle Cell Tendency	☐	☐	History of heart Murmur	☐	☐
Repeated bone or joint injuries	☐	☐	Surgery within past year	☐	☐	Kidney diseases/infections	☐	☐
Fractures within past year	☐	☐	Diabetes	☐	☐	Seizures	☐	☐

Tetanus (shot date if known) ____________ Any Current Medications: ☐ ☐ List: ____________ ____________ ____________ ____________

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The Section Below MUST Be Completed By A Licensed Medical Doctor (MD) ONLY:

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:	

If Cleared to participate check ONE appropriate category of play: (Doctor only)

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

Restrictions if any:

( ) **NOT CLEARED** 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 contra-indicate 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 Stamp:

DOCTORS NAME (Printed): ______________________________

DOCTORS SIGNATURE: ______________________________ **License #:** ______________