Pacific Coast Youth

Football/Cheerleading Conference, Inc.

PHYSICAL EXAM FORM

Revised 1/18

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:** _______________ _______________ _______________ _______________

* *

* **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:			

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:	
( ) 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 NAME (Printed):

_____
(MD, NP, or PA)

DOCTORS SIGNATURE: _____ **License #:** _____
Doctors Stamp: