Physical Form (Must be dated after April 1, 2020)

Child’s Name:

Age:

Date of Birth: / /

Any Known Allergies: Yes/No. If yes, please list allergies:

Any Known Disabilities: Yes/No. If yes, please list any:

Physician’s Statement of Health:

I certify that I have examined:

and have found no gross evidence of any abnormality that will keep him/her from participating in the Youth Sports Program.

Physician’s Name:

Address:

Phone

Signature:

Date:

Physical Form (Must be dated after April 1, 2020)



**DR STAMP REQUIRED HERE TO BE VALID**

