



P.O. BOX 443
PLEASANTON, CA 94566
(925) 277-8266

CONTACT FOOTBALL PHYSICAL EXAMINATION FORM

PLEASE COMPLETE THE FOLLOWING:

1. Name of Player: _____

2. Please indicate whether your child has any medical conditions of which the League should be aware (e.g. allergies, asthma, medication, etc.):

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PARENT SIGNATURE _____ **DATE** _____

TO BE COMPLETED BY PHYSICIAN:

Height _____ Weight _____ Blood Pressure _____ Ears _____

Eyes _____ Nose _____ Throat _____ Heart _____

Lungs _____ Hernia _____ Abdomen _____

_____ Player MAY participate in contact football.

_____ Player IS UNABLE to participate in contact football.

PHYSICIAN SIGNATURE _____ **DATE** _____