Physical Form (Must be for this Calendar Year, dated after April 1st

Childs 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: ____________________

Physicians 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.

Physicians Name: ____

Address: ______________________________ Phone ______________________

Signature: ___________________________________ Date: _________________

Physical Form (Must be for this Calendar Year, dated after April 1st

____

DR STAMP REQUIRED HERE TO BE VALID