BROOKLYN SKYHAWKS FOOTBALL
PLAYER MEDICAL FORM (2024)

DIVISION:	PLAYER'S NAME:	DOB:
PARENT/GUARDIAN NAME:		RELATIONSHIP:

THIS FORM MUST BE COMPLETED AND RETURNED TO THE ORGANIZATION PRIOR TO THE ISSUANCE OF EQUIPMENT AND FULL CONTACT PRACTICES. YOUR CHILD WILL NOT BE ALLOWED TO PARTICIPATE IN FULL CONTACT UNLESS THIS FORM IS COMPLETED.

CAMP FORMS ARE NOT ACCEPTED

MEDICAL EXAMINATION

This part must be completed by a licensed physician.

General Appearance: _____ Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: _____ Ears: _____ Nose: _____ Throat: _____ Hearing: _____

Heart: _____ Lung: _____ Abdomen: _____ Extremities: _____

Hernia: _____ Epilepsy/Convulsions: _____ History of Seizures: _____

Asthmatic **Yes ( ) No ( )** If Yes, please specify the type of medication and dosage:

Allergy to Food **Yes ( ) No ( )** If Yes, please specify:

Allergy to Medication **Yes ( ) No ( )** If Yes, please specify:

Describe any abnormal findings and/or handicapping conditions (Mental or physical):

Is this child **physically <u>able</u>** to participate in the strenuous sport of full collision tackle football? **Yes** ( ) **No** ( )

I have examined the above child and reviewed his health history. In my opinion he is physically able to engage in the strenuous sport of full collision tackle football **(American Football)**. I understand that this information will be kept strictly confidential, and have answered all questions completely, accurately and truthfully and to the best of my knowledge.

Examining Physician:	Provider ID:
Address:	Phone:
Date:	