

BROOKLYN SKYHAWKS FOOTBALL

PLAYER MEDICAL FORM (2025)

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.		
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> CAMP FORMS ARE NOT ACCEPTED </div>		
MEDICAL EXAMINATION		
<i><u>This part must be completed by a licensed physician.</u></i>		
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:		