



Pacific Coast Youth Football/Cheerleading Conference, Inc.

PHYSICAL EXAM FORM

Revised 1/10

This form must be completed and the original copy submitted to the PCC Conference at certification

Association: _____ Date of Physical: _____

Candidate's Name: _____ Age: _____ D.O.B: _____

Division of Play: _____ Team Name/Mascot: _____

MEDICAL HISTORY: (Must be completed by parent prior to examination)

	Yes	No		Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries within past year	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/Contact	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Dental braces or bridges	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Tendency	<input type="checkbox"/>	<input type="checkbox"/>	History of heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Repeated bone or joint injuries	<input type="checkbox"/>	<input type="checkbox"/>	Surgery within past year	<input type="checkbox"/>	<input type="checkbox"/>	Kidney diseases/infections	<input type="checkbox"/>	<input type="checkbox"/>
Fractures within past year	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus (shot date if known) _____			Any Current Medications: <input type="checkbox"/> <input type="checkbox"/> List: _____					

The Section Below MUST Be Completed By A Licensed Medical Doctor (MD) ONLY:

Height: _____ Weight: _____ Temp: _____ Blood Pressure: _____ Pulse: _____ Respiration: _____

	NORMAL		NORMAL
1. EYES		10. MUSCULOSKELETAL, ROM, STRENGTH	
2. EARS, NOSE, THROAT		NECK	
3. MOUTH AND TEETH		SPINE	
4. NECK		SHOULDERS	
5. CARDIOVASCULAR		ARMS/HANDS	
6. CHEST AND LUNGS		HIPS	
7. ABDOMEN		THIGHS	
8. NEUROMUSCULAR		KNEES	
		ANKLES	
9. GENITALIA-HERNIA (Male)		FEET	

ABNORMAL FINDINGS If any:	
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If Cleared to participate check ONE appropriate category of play: (Doctor only)

() Flag Football () TACKLE Football () Cheerleading w/ Stunting () Cheerleading w/o Stunting

Restrictions if any:

() NOT CLEARED to Participate in sport () Refer to Family Physician For Clearance

I, hereby my signature below, do certify that I am licensed by the state and am qualified in determining that: (Childs Name:) _____ is physically fit and I have found no medical or observable conditions which would contra-indicate him/her from participating in youth flag football, tackle football, cheer, dance, step or athletic activities. I am therefore clearing this individual for athletic participation.

DOCTORS NAME (Printed): _____

DOCTORS SIGNATURE: _____ License #: _____

Doctors Stamp: