

MONTICELLO AREA FOOTBALL & CHEERLEADING ORGANIZATION
PO Box 153
ROCKHILL, N.Y. 12775
PHYSICAL FORM

PLAYER/CHEERLEADER (CIRCLE ONE) **NAME** _____

ADDRESS: _____ **PHONE:** _____

MEDICAL HISTORY: Has your child had any of the following? (Circle answer)

1.	Any sever injuries, accidents or broken bones? If yes specify:	YES	NO
2.	Hospitalized for any length of time? If yes specify:	YES	NO
3.	Allergy to any medications or insect bites? If yes specify:	YES	NO
4.	Is your child currently taking any drugs, medications or undergoing any treatments? If yes specify:	YES	NO
5.	Does your child have headaches or blurred vision?	YES	NO
6.	Does your child have sight in both eyes?	YES	NO
7.	Does your child wear glasses or contact lenses?	YES	NO
8.	Does your child have trouble breathing through his/her mouth?	YES	NO
9.	Does your child have frequent nosebleeds?	YES	NO
10.	Does your child wheeze, cough or have shortness of breath?	YES	NO
11.	Have you ever been told your child has a heart murmur or heart problem?	YES	NO
12.	Has your child ever had a hernia or rupture?	YES	NO
13.	Does your child have any problem hearing?	YES	NO
14.	Are there any other medical conditions your child has that should be noted? If yes specify:	YES	NO

PARENT AUTHORIZATION

TO THE BEST OF MY KNOWLEDGE, THIS HEALTH HISTORY IS CORRECT AND I HEREBY GIVE PERMISSION FOR PARTICIPATION IN THE MONTICELLO AREA FOOTBALL & CHEERLEADING ORGANIZATION PROGRAM.

SIGNATURE OF PARENT/GUARDIAN _____

TO BE FILLED OUT BY THE EXAMINING PHYSICIAN:

DOB: _____ **HEIGHT:** _____ **WEIGHT:** _____

BP _____ **HEART RATE** _____

MAY THIS CHILD PARTICIPATE IN VIGOROUS FOOTBALL/CHEERLEADING PROGRAM? YES NO
CHILD'S GERNERAL PHYSICAL CONDITION GOOD OTHER _____

COMMENTS:

PHYSICIAN'S SIGNATURE _____