

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 abno participating in the Youth Sports Program.	ormality that will keep him/her from
Physicians Name:	
Address:	Phone
Signature:	Date:
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DR STAMP REQUIRED HERE TO BE VALID