

Team: _____

SANDY SPRINGS YOUTH FOOTBALL & CHEERLEADING PHYSICAL EXAM

Cheerleader/Player Name: _____

MEDICAL HISTORY (To be completed by Parent/Guardian)
(Please circle YES or NO)

YES NO Allergies (If yes, please list) _____
YES NO Asthma _____
YES NO Heart trouble or heart murmur _____
YES NO Diabetes _____
YES NO Shortness of Breath _____
YES NO Frequent or severe back pain _____
YES NO Frequent or severe headaches _____

List ALL medications used regularly:

Other medical information:

TO BE COMPLETED BY PHYSICIAN:

Fax: 404-921-0075

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Lymphatic _____
Head _____
Eyes _____
Throat _____
Spine _____
Chest/Lungs _____
Heart _____
Abdomen _____
Extremities _____
Other _____

Physician Signature _____

Date _____