

ROCKAWAY TOWNSHIP ROCKETS FOOTBALL

2009 PHYSICAL FORM

(not to be completed before June 1, 2009)

Section 1: Filled out by parent or legal guardian.

PLAYERS NAME: _____ AGE: _____

ADDRESS(NO PO Box): _____

PARENT OR LEGAL GUARDIAN: _____

Address if different from above:

MEDICAL HISTORY: Answer all questions– Does your child now have or ever had any of the following:

#	ITEM	Yes	No	#	ITEM	Yes	No
1	Frequent Headaches			10	Diabetes		
2	Dizzy Spells/ Fainting			11	Testicular Problems		
3	Epilepsy or Convulsions			12	Hernia		
4	Anemia/Blood Disease			13	Eye Problems		
5	Heart Disease/ Murmur			14	Ear or Hearing Problems		
6	Breathing Problems			15	Oral or Dental Problems		
7	Asthma			16	Childhood Diseases		
8	Pneumonia			17	Accidents, Injuries, Fractures		
9	Joint or Back Deformities			18	Other		

Explain Briefly any YES answers from above:

Parent or Legal Guardian Signature:

SECTION 2: To be completed by Examining Physician.

✓ = NORMAL + = ABNORMAL

HEAD		CHEST		ABDOMEN	
NECK		HEART		EXTREMITIES	
LUNGS		EYES		NEROLOGICAL	
ENT		SPINE			

TESTES: Desent Bilat _____ (Y / N)

HERNIA _____ (Y / N)

Comment on above abnormals: _____

Child is medically qualified to participate in full activities without restrictions.

Child is medically qualified to participate in activities subject to the following limitations:

Due to abnormality found on exam, child should be referred back to private physician for clearance.

DATE _____ PHYSICIANS SIGNATURE _____

PRINT NAME _____

Private Physician

RTFootball Physician

RTFOOTBALL USE ONLY

Amount Paid: _____ Cash _____ Check _____ Check # _____