

**DMAFB YOUTH CENTER**  
**PHYSICAL FORM**

**PRIVACY ACT STATEMENT:**

**AUTHORITY:** 10 USC 8013; 44 USC 3101; EO 9397

**PRINCIPAL PURPOSES:** To provide Youth Programs with authorization for medical treatment in emergency situations; authorization for field trips; identify children and sponsor; record known allergies; record special needs requirements; and record special instructions.

**ROUTINE USES:** Form may be furnished to civilian doctors or hospitals in the course of obtaining emergency medical attention for children. Information furnished may be disclosed, upon request, to other Federal, state or local governmental agencies in the pursuit of their official duties. Finally, it may be used for other lawful purposes including law enforcement and litigation.

**DISCLOSURE IS VOLUNTARY:** Failure to furnish information, including SSN, will result in denial of admission of child(ren) to Youth Programs. SSN is used for positive identification of individuals and records.

**PHYSICAL FORM**

This is to certify that \_\_\_\_\_, age \_\_\_\_\_, has been examined on \_\_\_\_\_ and found to have no physical defects, illness or disease that would disqualify him/her from participating in the sport(s) checked below. At the time of the examination, \_\_\_\_\_, weighed \_\_\_\_\_ lbs and is \_\_\_\_\_ ft \_\_\_\_\_ inches tall.

_____ Baseball	_____ Basketball	_____ Other _____
_____ Softball	_____ Soccer	
_____ Flag Football	_____ First Steps	

This part is to filled out by the player and parents prior to any examination. If you answer "Yes" to any of the questions below, please use the space provided on the backside of this form to respond with the proper number.

- |     | <b>Yes</b> | <b>No</b> | <b>Has the player had any:</b>                          |
|-----|------------|-----------|---|
| 1.  | ___        | ___       | Chronic/recurrent illness?                              |
| 2.  | ___        | ___       | Illness lasting over one week?                          |
| 3.  | ___        | ___       | Hospitalization?  |
| 4.  | ___        | ___       | Surgery?  |
| 5.  | ___        | ___       | Missing organs (eye, kidney)?                           |
| 6.  | ___        | ___       | Medication allergy?                                     |
| 7.  | ___        | ___       | Problems with the heart or blood pressure?              |
| 8.  | ___        | ___       | Chest pain with exercise?                               |
| 9.  | ___        | ___       | Dizziness, fainting with exercise?                      |
| 10. | ___        | ___       | Dizziness, fainting, frequent headaches or convulsions? |

- 11.    \_\_\_            \_\_\_    Concussion/unconsciousness?
- 12.    \_\_\_            \_\_\_    Heat exhaustion, heat stroke or other problems with heat?
- 13.    \_\_\_            \_\_\_    Injuries requiring a doctor's attention?
- 14.    \_\_\_            \_\_\_    Neck Injury?
- 15.    \_\_\_            \_\_\_    Knee Injury?
- 16.    \_\_\_            \_\_\_    Knee Surgery?
- 17.    \_\_\_            \_\_\_    Ankle Injury?
- 18.    \_\_\_            \_\_\_    Other serious injuries?
- 19.    \_\_\_            \_\_\_    Broken bones (fractures)?

**Does the player:**

- 20.    \_\_\_            \_\_\_    Wear glasses/contact lenses?
- 21.    \_\_\_            \_\_\_    Wear dental bridges/braces/plates?
- 22.    \_\_\_            \_\_\_    Take any medication?
- 23.    \_\_\_            \_\_\_    Is there any reason why this player should not participate in sports?

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Date of last known tetanus shot \_\_\_\_\_

Is there anything else you would like to note or discuss with the medical provider?

\_\_\_\_\_  
 Doctor's name (Print)

\_\_\_\_\_  
 Doctor's Signature/Date

\_\_\_\_\_  
 Hospital stamp or Doctor's Stamp

**This physical is good for 12 months from the above date.**