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.

	Yes	**No**	**Has the player had any:**
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?

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.