SCARBOROUGH FOOTBALL CLUB
PHYSICAL EXAMINATION FORM

TO PARENTS: Please complete the top of this form and ask your physician to complete the physical examination portion. Please return this form to your Division Coordinator.

Name of Student: _____Parent/Guardian:_____
Address: _____ Telephone: _____
Grade (Entering in Fall '10): _____

PHYSICIAN'S REPORT OF EXAMINATION

D.O.B.____/_____/_____Age:_____ HT:_____ WT:_____ B/P:_____ Pulse Rate_____
Eyes:_____R 20/____ L 20/____ Ears: _____ R____/15 L____/15
Significant Past Illness or Injury: _____

PHYSICAL EXAMINATION:

	Normal	Abnormal	Describe abnormal findings
Skin	_____	_____	_____
Head & Neck	_____	_____	_____
Nose	_____	_____	_____
Mouth & Throat	_____	_____	_____
Thyroid	_____	_____	_____
Lymph Nodes	_____	_____	_____
Respiratory	_____	_____	_____
Cardiovascular	_____	_____	_____
Liver	_____	_____	_____
Spleen	_____	_____	_____
Hernia	_____	_____	_____
Musculoskeletal	_____	_____	_____
Neurological	_____	_____	_____
Genitalia	_____	_____	_____
Laboratory: Urinalysis	_____	_____	_____
Other: _____	_____	_____	_____

IMMUNIZATIONS GIVEN TODAY: _____
VARICELLA: DATE OF DISEASE: _____ **DATE OF VACCINE:**_____

On the basis of my knowledge of this student I would recommend the following activity:

	Restricted	Unrestricted	Please specify(i.e.non-contact, etc.)
Competitive sports:	_____	_____	_____
Physical Education:	_____	_____	_____

Physician's Name (printed) _____
Physician's Signature _____
Telephone: _____ **Date of Physical:** _____