

Child's Address _____

Insurance Provider _____

Member ID or Group # _____

Phone Number _____

DAMF Physical Exam Report 2024 Form cannot be dated prior to June 1, 2024

Child's Name: _____

Age: _____

Weight: _____

Height: _____

Blood Pressure: _____

Heart: _____

Head & Neck: _____

Hernia: _____

Lungs: _____

Abdomen: _____

Back: _____

Extremities: _____

Allergies: _____

HAS THE CHILD HAD ANY INJURIES OR OPERATIONS IN THE LAST YEAR? _____
IF YES EXPLAIN:

This certifies that _____ in my professional opinion, is physically
(child's name)
and mentally fit to participate in the Derry Area Midget Football Program.

(Date)

(Physicians Signature)

PHYSICIAN COMMENTS:

THE DERRY AREA MIDGET FOOTBALL BOARD OF DIRECTORS RESERVES THE RIGHT TO REFUSE PARTICIPATION OF ANY PHYSICALLY OR MENTALLY HANDICAPPED CHILD. THIS DECISION WILL BE MADE SOLELY ON THE BEST INTEREST OF EACH INDIVIDUAL CHILD.

OTHER SIDE

All information must be completed prior to the beginning of season to participate

Questionnaire

If you answer yes to any question circle and explain.

1. Have you ever consulted a physician, practitioner, clinic or institution for or ever had:
Epilepsy, Fainting Spell, Syphilis, Tuberculosis, Chest Pains, Rheumatism, Arthritis, Diabetes, Tumor, Ulcer, Cancer, Goiter, Hernia, Anemia or Asthma? Y ___ N ___

A.) Disease, Injury or Disorder of Heart, Lungs, Brain, Nerves, Eyes, Ears, Spine, Back, Bones, Joints, or any Physical Abnormality or Mental Disorder? Y ___ N ___

B.) High Blood Pressure, Sugar or Albumin or Blood in the Urine, or any disorder or disease of the Kidneys, Bladder, Stomach, Liver, Genito-Urinary Organs, Intestines, or Gall Bladder? Y ___ N ___
2. During the past five years, have you had:

A.) Medical or Surgical advice from any physician, practitioner, Hospital or Clinic? Y ___ N ___

B.) X-ray's, Electrocardiograms, Blood, Urine or Glucose Tests, or any other Laboratory Test or examination? Y ___ N ___
3. Are you now on a diet or medication as prescribed by a Physician, Practitioner, hospital or Clinic? Y ___ N ___
4. During the past ten years, have you had any illness or injury not mentioned in this application? Y ___ N ___
5. To the best of your knowledge, is there any reason to believe you are not in good health? Y ___ N ___
6. A.) Height _____ FT _____ IN
B.) Weight _____ LBS
C.) Change (+ or -) in the past year? + _____ LBS. - _____ LBS
D.) Cause of weight change if any? _____

Name of personal Physician: _____
Address and Phone Number: _____

PLEASE PROVIDE WRITTEN DIRECTIONS TO YOUR HOME FROM THE HIGH SCHOOL BELOW: