

**TUCSON YOUTH FOOTBALL & SPIRIT FEDERATION, INC.**  
**Physical Examination**  
**PHYSICALS MUST BE DATED AFTER JANUARY 1<sup>ST</sup> OF THE CURRENT YEAR**

Name \_\_\_\_\_ Date of Examination \_\_\_\_\_

Football/Spirit \_\_\_\_\_ Association \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender M or F

Address \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ Pupils Equal Unequal

Vision R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Glasses/Contacts Yes No

<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	<b>MUSCULOSKELETAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
Appearance	_____	_____	Neck	_____	_____
Skin	_____	_____	Back	_____	_____
Eyes/Ear/Nose	_____	_____	Shoulder/Arm	_____	_____
Throat/Or pharynx	_____	_____	Elbow/forearm	_____	_____
Lymph Nodes	_____	_____	Wrist/hand	_____	_____
Heart	_____	_____	Hip/thigh	_____	_____
Pulses	_____	_____	Knee	_____	_____
Lungs	_____	_____	Leg/ankle	_____	_____
Abdomen	_____	_____	Foot	_____	_____
Genitalia/Hernia	_____	_____			

**CLEARANCE**

Cleared for Athletics

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not Cleared for \_\_\_\_\_ Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

Name of Physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Physician \_\_\_\_\_ MD / DO / NP / PA-C