WALLED LAKE BRAVES
2011 PHYSICAL EXAMINATION FORM

NAME: _____

ADDRESS: _____

TELEPHONE: _____CELL: _____

FATHER: _____WORK PHONE: _____

MOTHER: _____WORK PHONE: _____

DOCTOR: _____PHONE: _____

INSURANCE INFORMATION_____

(TO BE COMPLETED BY PHYSICIAN)

DATE OF BIRTH: _____ WEIGHT: _____HEIGHT:_____

SYSTEM	NORMAL	ABNORMAL
Urinalysis		
Lungs		
Vision		
Heart		
Blood Pressure		
Abdomen		
Pulse Rate		
Hernia		
Ear, Nose, Throat		
Genitalia		
Orthopedic		
Neurological		
Teeth		
Muscular		
Thyroid		
Chest		

Recommendations or comments:

Note to Parents and Physicians: Blood work is not required, however, it is recommended.

I certify that I have examined the above child and recommend him/her as being able to participate and complete in supervised athletic activities including Football/Cheerleading.

Date: _____

Physician's Signature: _____