Proof of Physical Exam Date:

Player Information

September Grade: _____

Last Name: _____ First: _____

Birth Date: _____ Sex: M F

Address: _____

Home Phone: _____

Cell Phone: _____

General Health

(To be completed by parent or guardian)

In the space provided, please list any allergies, medication, or any other pertating condition that could hamper physical exertion.

_____

_____

_____

_____

_____

Physician Use

(Basketball Players Must Have This Completed By a Licensed Physician)

Col _____ Sex _____ Height _____ Weight _____

Nutrition _____ Skin _____ Glands _____ Eyes R _____ L _____

Nose & Throat _____ Ears R _____ L _____

Heart _____ Lungs _____ _____

Deformities _____ Nervous System _____

General physical comments

(allergies, etc.)

_____

_____

_____

_____

This certifies that I have this day examined the above named patient and have found him/her to be of normal development, in reasonable health and physically to play basketball.

Signed: _____ Date: _____

_____

Physician's Printed name

Address: _____

_____

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