RIVER CITY YOUTH SPORTS CONFERENCE
Pre-Participation Physical Evaluation Form

SECTION A: TO BE COMPLETED BY PARENT/GUARDIAN AND ATHLETE

Athlete Information

Name: _____Date of Birth: _____ Age: ____ Gender: _____

Address: _____City: _____ State: _____ ZIP:_____

School/Team: _____

Sport(s): _____

Emergency Contact Information

Parent/Guardian Name: _____
Phone: (____) _____-_____

Medical History (Check Yes or No)

☐ Yes ☐ No Has a doctor ever denied or restricted your participation in sports?
☐ Yes ☐ No Do you have any ongoing medical conditions (e.g., asthma, diabetes)?
☐ Yes ☐ No Have you ever passed out or nearly passed out during exercise?
☐ Yes ☐ No Do you have a history of seizures or concussions?
☐ Yes ☐ No Are you currently taking any medications or supplements?
☐ Yes ☐ No Do you wear glasses, contacts, or protective eyewear?
☐ Yes ☐ No Have you ever had surgery? If yes, explain below.
Explain any "Yes" answers:
_____
_____
_____

Athlete Information

Name: _____Date of Birth: _____

SECTION B: TO BE COMPLETED BY LICENSED MEDICAL PROFESSIONAL

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____ bpm

Vision (R): _____ (L): _____ Corrected: ☐ Yes ☐ No

Physical Examination (Check Normal or Abnormal)

Heart/Lungs: ☐ Normal ☐ Abnormal (explain): _____

Abdomen: ☐ Normal ☐ Abnormal (explain): _____

Musculoskeletal: ☐ Normal ☐ Abnormal (explain): _____

Eyes/Ears/Nose/Throat: ☐ Normal ☐ Abnormal (explain): _____

Skin: ☐ Normal ☐ Abnormal (explain): _____

Neurological: ☐ Normal ☐ Abnormal (explain): _____

Comments or Recommendations:

_____

_____

Clearance (Check one):

☐ Cleared for all sports without restriction

☐ Cleared with the following restrictions: _____

☐ Not cleared for participation due to: _____

I hereby certify that I am a licensed state examiner and have examined the above-named individual and understand that he/she will be participating in River City Sports Conference athletic programs. I hereby attest that the individual is physically fit and I have found no medical reason that would prevent this individual from participating; therefore, I am clearing this individual for athletic participation without limitation.

Provider Signature: _____Printed Name _____Date:_____

Office Address: _____ MEDICAL STAMP IN AREA BELOW

Phone Number:_____

Parent/Guardian Consent and Acknowledgement

I certify that the above information is accurate and complete. I give consent for my child to participate in athletic activities and authorize emergency medical treatment if necessary.

Parent/Guardian Signature: _____ Date: _____

Athlete Signature: _____ Date: _____