Centerville Youth Lacrosse
SPORTS PHYSICAL EXAMINATION

Player's Name: _____ Date of Birth: ____/____/____

Street Address: _____

City: _____ State: _____ Zip Code: _____

TO BE COMPLETED BY PHYSICIAN

Date of Examination: ____/____/____ Height _____ Weight _____

Physician's Name (Please Print/Stamp)

_____

Street Address

_____

City, State, Zip Code

_____

Telephone

_____

I certify that I have examined this athlete and found him medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician's assistant, or family nurse practitioner (Doctor of Chiropractic Medicine is not satisfactory).

Physician Signature _____ Date _____

PARTICIPATION RESTRICTIONS:

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