

Antioch Little League

PHYSICIAN'S STATEMENT/MEDICAL APPROVAL

Name of Player _____

Print Player Name

Address _____ City _____ State _____ Zip _____

Height _____ Weight _____ Age _____

Significant Past Illness or Injury _____

Eyes: R: 20 _____ : 20 _____ Ears: R: _____ 15 L: _____ 15

Respiratory _____

Cardiovascular _____ Blood Pressure _____

Liver _____ Spleen _____ Hernia _____

Musculoskeletal _____

Neurological _____

Allergies _____

Completed Immunizations: Polio (date) _____

Tetanus (date) _____

Comments: _____

In my opinion _____ is physically

Print Player Name

able to participate in Little League Baseball.

Signed By: _____ Date of Examination: _____

Telephone: _____ Address: _____

Return to Player Agent