For office use only

PHYSICIAN'S REPORT

www.ridgeyouthsports.com

PLAYER INFORMATION

Participating in: *(check all that apply)* ❑Cheer ❑Flag Football ❑Tackle Football ❑Lacrosse ❑Basketball ❑Softball

Player's Last Name First Name

Date of Birth / / High School Graduation Year Home Phone

Allergies (Yes or No, if Yes, please identify)

Address Email:

State Zip

Insurance Carrier Policy #

EMERGENCY CONTACT INFORMATION

Parent #1 Name Home Phone:

Cell Phone: Work Phone:

Parent #2 Name Home Phone:

Cell Phone: Work Phone:

Emergency Contact Name (other than parent) Relationship to Child

Home Phone: Cell Phone:

TO BE FILLED OUT BY PHYSICIAN

Physical must be within 365 days of the start of practice.

Date of Examination Height Weight Blood Pressure

Vision R 20/ L 20/ Contacts YES NO Glasses YES NO

Medical History, Allergies, Respiratory Problems, etc. Please inform us of any medication taken regularly or any physical/medical problems that we should be aware of.

Other Physician Remarks *(use back of form if needed)*

I CERTIFY THAT THIS CHILD MAY PLAY: ❑FULL-CONTACT SPORTS ❑NON-CONTACT SPORTS

Physician's Signature Date

Physician's Name Phone ( )

Registered child WILL NOT BE ABLE TO PARTICIPATE in this Program until this Physician's Report is completed and returned to Ridge Youth Sports, Inc. at 65 South Maple Ave • 2nd Floor • Basking Ridge, NJ 07920