

**OSAN YOUTH SPORTS PROGRAM**  
**Physical Examination/Screening/Medical History Form**  
*IAW AFMAN 34-804 Each child must have a yearly physical examination to participate in youth sports.*

*(To be completed by parent/sponsor)*

|                        |                       |                               |
|------------------------|-----------------------|-------------------------------|
| <b>Youth's Name:</b>   | <b>Date of Birth:</b> | <b>Date of Last Physical:</b> |
| <b>Sponsor's Name:</b> | <b>Rank:</b>          |                               |
| <b>Address:</b>        | <b>Home Phone:</b>    | <b>Work Phone:</b>            |
|                        | <b>EMAIL:</b>         |                               |

***Emergency Contact***

|                           |                           |
|---------------------------|---------------------------|
| <b>Name:</b>              | <b>Relationship:</b>      |
| <b>Home Phone Number:</b> | <b>Duty Phone Number:</b> |

\_\_\_\_\_

**Parent's Signature**

\_\_\_\_\_

**Date**

*(To be completed by physician)*

|   | YES                              | NO                       |
|---|----------------------------------|--------------------------|
| There are no medical problems for the youth named above that would prevent safe participation in a youth sports league. He/she is medically qualified to participate in the Elmendorf Youth Sports Program.   | <input type="checkbox"/>         | <input type="checkbox"/> |
| Is vision correction required for participation?                      Glasses/Contacts  | <input type="checkbox"/>         | <input type="checkbox"/> |
| Are there health problems that should be evaluated or treated before participation in a recreational sports league?   | <input type="checkbox"/>         | <input type="checkbox"/> |
| Are there medical problems/chronic (on-going) health problems that may affect participation? (e.g., Asthma)<br>If YES, please provide detailed information about the specific health issue(s) and the effect on the athlete:<br><br>_____<br><br>_____<br><br>_____ | <input type="checkbox"/>         | <input type="checkbox"/> |
| <i>Coaches must be alert to children who have chronic (on-going) health problems.</i>   |                                  |                          |
| <b>Date:</b>  | <b>Printed Physician's Name:</b> |                          |
| <b>Signature of Examining Physician:</b>  |                                  |                          |