

**PHYSICAL EXAMINATION/MEDICAL HISTORY FORM
2012 BLUE CHIP FOOTBALL ACADEMY**

LAST NAME: _____ FIRST NAME: _____ M.I. _____

D.O.B. ____/____/____ SCHOOL: _____

HOME ADDRESS: _____

HOME CITY: _____ STATE: _____ ZIP: _____

HEALTH HISTORY – Please fill in dates where appropriate.

Illness
Frequent Ear Infections _____
Heart Defect/Disease _____
Convulsions _____
Diabetes _____
Bleeding/Clotting Disorders _____
**Asthma _____

***Allergies
Hay Fever _____
Ivy Poisoning _____
*Insect Stings _____
Medicine _____
Foods _____
*What insects? _____

Disease
Chicken Pox _____
Measles _____
German Measles _____
Mumps _____

***Please describe care necessary to handle asthma (i.e. use of inhaler) _____

***If Epi-Pen is required to handle allergic reaction, individual must supply one.

Operations or serious injuries (with dates): _____

Chronic or recurring illness: _____

Any specific activities to be restricted? _____

Name of Dentist? _____

Name of Doctor? _____

Name of Medical Insurance Carrier: _____ Policy#: _____

Address: _____ Phone: _____

IMMUNIZATION HISTORY with DATES

DTP: 1. _____
2. _____
3. _____
4. _____
5. _____

MMR:
(combined)
1. _____
2. _____

MENINGOCOCCAL:
(not required)
1. _____

*If you do not have your childhood immunization history, you **MUST** receive a Td booster and have an MMR titer completed!*

MEDICAL EXAMINATION – To be filled in by licensed physician. This examination should be performed within one calendar year of arrival at the 2011 B.C.F.A. Examination for some other purpose within this period is acceptable.

Code: V - Satisfactory	X - Not Satisfactory (explain)	O – Not examined
Ht _____	Wt _____	Blood Pressure _____ Urinalysis _____
Eyes _____	Lungs _____	Allergy _____
Glasses _____	Abdomen _____	Please describe degree of allergic reaction _____
Contacts _____	Hernia _____	_____
Ears _____	Extremities _____	General Appraisal _____
Nose _____	Posture (spine) _____	
Throat _____	Skin _____	
Heart _____		
Special Diet _____		
Current Medications _____		

Please examine the person described herein and have reviewed the health history. It is my opinion that this individual is physically able to engage in program activities except as noted above.

Examining Physician: _____ Date: _____

Please Print Physician's Name: _____ Phone: _____

Address: _____

RETURN TO: Blue Chip Football Academy • PO Box 4078 • Plymouth, MA 02361