PHYSICIAN'S REPORT

PHYSICIAN'S STAMP

CHEERLEADER INFORMATION

Last Name First Name

Date of Birth / / Home Phone

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

Address Email:

State Zip

Insurance Carrier Policy #

PARENT/GUARDIAN AND EMERGENCY CONTACT INFORMATION

Parent/Guardian #1: Home Phone:

Cell Phone: Work Phone:

Parent/Guardian #2: Home Phone:

Cell Phone: Work Phone:

Emergency Contact Name (other than above):

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 PARTICIPATE IN THE RJR CHEERLEADING PROGRAM WITHOUT RESTRICTIONS

Physician's Signature Date

Physician's Name Phone ( )

Registered athlete WILL NOT BE ABLE TO PARTICIPATE in the RJR Competition Cheerleading program until this Physician's Report is completed and emailed to juniorramscheerleading@gmail.com.