PHYSICAL EXAMINATION/MEDICAL HISTORY FORM
2017 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	***Allergies**	**Disease**
Frequent Ear Infections_____	Hay Fever_____	Chicken Pox_____
Heart Defect/Disease _____	Ivy Poisoning_____	Measles _____
Convulsions _____	*Insect Stings_____	German Measles_____
Diabetes _____	Medicine_____	Mumps _____
Bleeding/Clotting Disorders_____	Foods_____	
**Asthma_____	*What insects? _____	

***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* **2016 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_____
Glasses_____ Abdomen_____ Allergy_____
Contacts_____ Hernia_____
Ears_____ Extremities_____ Please describe degree of allergic reaction_____
Nose_____ Posture (spine) _____ _____
Throat_____ Skin_____
Heart_____ General Appraisal_____

Special Diet _____

Current Medications _____

Please examined 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 • 239 Chanterwood Rd. • Lee, MA 01238