



# Fairchild AFB Youth Programs

## Youth Sports Physical Examination

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
(Last, First MI)

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

*To be completed by your medical provider*

Date of physical examination: \_\_\_\_\_  
(DD/MM/YYYY)

### RESULTS OF PHYSICAL EXAMINATION

Youth cleared to play sports with no exceptions: YES  NO

Youth cleared to play sports with exceptions: (Please explain)

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Youth not permitted to participate in sports at this time: (Please explain)

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### MEDICAL PROVIDER'S INFORMATION

\_\_\_\_\_  
Medical Provider's Printed Name or Stamp

\_\_\_\_\_  
Medical Provider's Signature

\_\_\_\_\_  
Date