



Black Hills Youth Football and Cheer League

P.O. Box 999, Box Elder, SD 57719

Email: Bhyfl.football.cheer@gmail.com Phone: 605-791-3381

Pre-participation Physical Form

Date of Exam: ____/____/____

Athletes Name: _____ Sex: ☐ M ☐ F Age: _____

Date of Birth: ____/____/____ Grade upcoming fall : _____ Sport (*circle one*): Football / Sideline Cheer

FULL Address: _____

Medical Screening Questions

(Please check Yes or No. If you answer Yes, please provide additional details on the back of this form.)

Question	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have any ongoing medical conditions or health concerns?	☐	☐
3. Do you have any allergies to medications, foods, or insect stings? If yes, please list: _____	☐	☐
4. Have you ever had a headache, passed out, or nearly passed out during or after exercise?	☐	☐
5. Does your heart race, flutter, or skip beats during exercise?	☐	☐
6. Have you ever had chest pain, discomfort, or pressure during exercise?	☐	☐
7. Has a doctor ever told you that you have asthma?	☐	☐
8. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
9. Have you had infectious mononucleosis (mono) within the past month?	☐	☐
10. Have you ever had a head injury or concussion?	☐	☐
11. Have you ever been hit in the head or had a fall that caused confusion, memory loss, or other concussion symptoms?	☐	☐
12. Have you ever had a seizure?	☐	☐
13. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
14. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
15. When exercising in hot weather, have you ever had severe cramps, become ill, or needed medical attention?	☐	☐

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Current Medications:

Does the athlete carry an inhaler, EpiPen, or other emergency medication?

☐ Yes ☐ No

If yes, please explain:

Injury History

(For the following questions, if Yes, please indicate the body part(s) and provide details on the back of this form.)

Question	Yes	No
1. Have you ever had an injury (such as a sprain, muscle/ligament tear, tendon injury, or other injury) that caused you to miss practices, games, or activities?	☐	☐
2. Have you ever broken or fractured a bone or dislocated a joint?	☐	☐
3. Have you ever had a bone or joint injury that required X-rays, MRI, CT scan, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐
4. Have you ever had a stress fracture?	☐	☐

Injured Body Part(s):

Recent Illness

Have you tested positive for COVID-19 within the past 30 days? ☐ Yes ☐ No

Have you recently experienced any of the following symptoms?

☐ Fever ☐ Cough ☐ Sore throat ☐ Shortness of breath ☐ Unusual fatigue

If yes, please explain:

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Parent / Guardian Acknowledgment

I confirm that the information provided in this form is accurate to the best of my knowledge. I understand that it is my responsibility to notify the league/association of any changes in my child's health status.

I understand that athletes suspected of concussion or serious injury will be removed from participation and may not return until medically cleared according to league policy.

Parent/Guardian Name: _____

Signature: _____ Date: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

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Physician Examination (Provider Only)

Athletes Name: _____ Sex: ☐ M ☐ F Age: _____Date of Birth: ____/____/____ Grade upcoming fall : _____ Sport (*circle one*): Football / Sideline Cheer

Exam Area	Normal	Abnormal	Comments	Initials
Appearance	☐	☐		
Eyes/Ears/Nose/Throat	☐	☐		
Lymph Nodes	☐	☐		
Heart	☐	☐		
Pulses	☐	☐		
Lungs	☐	☐		
Abdomen	☐	☐		
Skin	☐	☐		
Neurological	☐	☐		
Musculoskeletal	☐	☐		
Neck	☐	☐		
Back	☐	☐		
Shoulder/Arm	☐	☐		
Elbow/Forearm	☐	☐		
Wrist/Hand	☐	☐		

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Exam Area	Normal	Abnormal	Comments	Initials
Hip/Thigh	☐	☐		
Knee	☐	☐		
Leg/Ankle	☐	☐		
Foot	☐	☐		

Athlete's Height _____ Athlete's Weight _____

Physician Clearance

☐ Cleared for participation without restrictions

☐ Cleared with recommendations for further evaluation, treatment, or follow-up:

☐ Not cleared for participation in:

☐ All sports

☐ Specific sport(s): _____

Reason:

Additional recommendations:

Physician Information

Physician Name: _____ Date: _____

Address: _____ Phone: _____

Physician Signature: _____

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