

PHYSICAL EXAMINATION CERTIFICATION

Mandatory ***annually*** by CIF for all students participating in high school sports

Valley Christian Academy

301 W. Whyte Avenue

Roseville, CA 95678

916/728-5500 Fax: 916/721-3305

Student's name: _____ Sex: M F

Address, City, Zip _____ Phone: _____

School year: _____ Grade: _____ Date of birth: _____

Physician's certificate:

I hereby certify that _____ was examined by me on _____
(date)

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____

Temperature: _____ Hernia? _____ Reflexes: _____

Orthopedics (report any problems): _____

Special instructions (i.e. diet, medications, precautions): _____

____ He/she was found physically fit to engage in all sports.

____ He/she does not have clearance to participate in _____

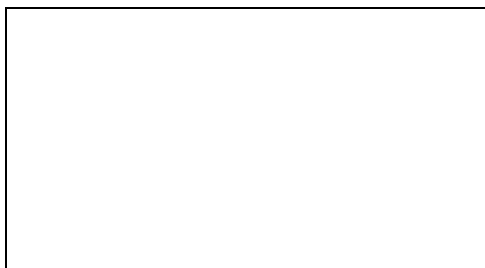
This physical is applicable for a period of one year from the date of signature below.

Attachment(s): Yes _____ No _____

Comments: _____

Physician's signature

Date signed



(*Official medical office address stamp needed in box)

(Parents: Please return this completed form to VCA