



Colusa Jr. Redhawks

P.O. Box 1243, Colusa, CA 95932

colusajrredhawks.com



Physical Form (must be for this Calendar Year, dated after April 1st)

Childs Name: _____ Age: _____

Date of Birth: ___/___/___

Any Known Allergies: Yes/No. If yes, please list allergies: _____

Any Known Disabilities: Yes/No. If yes, please list any: _____

Physicians Statement of Health:

I certify that I have examined: _____

And I have found no gross evidence of any abnormality that will keep him/her from participating in the Youth Sports Program.

Physicians Name: _____

Address: _____ Phone: _____

Signature: _____ Date: _____



Physical Form (Must be for this Calendar Year, dated after April 1st)

DR STAMP REQUIRED HERE TO BE VALID