

**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 \_\_\_\_\_

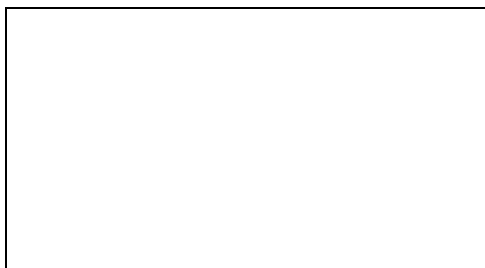
This physical is applicable for a period of one year from the date of signature below.

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