Physician Approval

Athlete Name

Gender

Height

Feet Inch

Weight

LBS

Grade

DOB

Fall Season **Winter Season** **Spring Season**

Statement By Physician or Approved HealthCare Provider (MD, DO, NP, PA)
For Interscholastic Participation

I hereby certify that I have examined the above mentioned student and find him/her physically fit to engage in high school baseball, basketball, cross country, field hockey, football, golf, gymnastics, ice hockey, lacrosse, soccer, softball, swimming, tennis, track & field, volleyball, wrestling, cheerleading and pom poms. (Please cross out any activity in which this student should not participate.)

_____

Signature of Physician/Approved Provider

_____ _____

Credentials Date

Transferred? Last High School Attended Year