

Sport: _____

IC – School use only
 Graduation year:

PHYSICIAN PERMIT FOR ATHLETIC PARTICIPATION

I hereby certify that I have examined (STUDENT NAME) _____ and that the student was found physically fit to engage in school baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, ice hockey, lacrosse, pom squad, soccer, softball, swimming, tennis, track and field, wrestling, volleyball.

(Please cross out any sport in which the student should not participate).

Student's Name: _____ Student's Birthday: _____

Student's Grade: _____

I have reviewed his/her medical history form and have cleared his/her participation in athletics without restrictions.

Date of Physical: _____
(Valid for 365 days unless rescinded)

Signature of Physician: _____
Physician (must be signed by MD, DO, NP, PAC, or DC)

PLEASE PRINT or PRACTICE STAMP:

PHYSICIAN'S NAME: _____

ADDRESS: _____

PHONE NUMBER: _____