IC

Graduation year:

PHYSICIAN PERMIT FOR ATHLETIC PARTICIPATION

I hereby certify that I have examined ____________________ 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: _______________________________

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Date of Physical: ____________________________ (Valid for 365 days unless rescinded)

Physician (must be signed by MD, DO, NP, PAC, or DC)

PLEASE PRINT

PHYSICIAN'S NAME: ____

ADDRESS: ____

____

____

PHONE NUMBER ____