



Physician's Authorization / Clearance for Participation

Name: _____

Gender: Female Male

Date of Birth ____ / ____ / ____

Age: _____

Church: _____

Grade: _____

Home Phone: _____

Date of Last Physical: _____

Physician: _____

Telephone: _____

Instructions: Please answer the following questions about your medical history. Explain any "yes" answers at the bottom of the page.

A. Student may participate in all track and field events: YES NO

B. Cleared after completing evaluation/rehabilitation for: _____

C. NOT Cleared for:

Collision

Contact

Non-contact

Strenuous

Moderate

Non-strenuous

Diagnosis: _____

Recommendation: _____

Examined by: Please provide Physician's/Provider's Stamp:

Physician's / Provider's Signature: _____

Signature Date: _____

(Parents: Please return completed form to Team Administrator.)