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.)