Completed Form Must Be Turned In To Athletic Office Prior To Participation

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