

Physical Examination Information

Camp Dates _____

Date ____/____/____

Name of Participant: _____ Age: _____ Birth date: ____/____/____

Each participant must **EITHER** attach a copy of a physician conducted sports examination applicable to this current academic year **OR** have a physician complete and then sign the form below.

Clearance: (circle one)

A. Cleared

B. Cleared after completing evaluation / rehabilitation for: _____

C. Not cleared for: Collision

Contact

Non-contact: Strenuous Moderately strenuous Non-strenuous

Due to: _____

Recommendation: _____

Signature of Physician: _____ Date: ____/____/____

Physician's Address: _____

Physician's Phone: _____