PHYSICIAN'S PERMIT FOR ATHLETIC PARTICATION

Student's Name: _____

Student's Birthday: _____

I hereby certify that I have examined the above named student and that the student was found physically fit to engage in School Basketball, Cheerleading, Cross country, Golf, Lacrosse, Soccer, Track and field, Volleyball
(please cross out any sport in which the student should not participate).

Date of Physical: _____ (valid for 365 days unless rescinded)

Signature: _____
(must be signed by MD, DO, NP, PAC or DC)

Please Print:
Physician's Name: _____

Address: _____

_____

Phone Number: _____