

SPORT / TEAM MEDICAL CLEARANCE FORM

School Year: 2009/2010

Student Name

Last: _____ First: _____

DOB: _____ Phone: _____

School: _____

Anticipated Team Activities

Fall: _____

Winter: _____

Spring: _____

A medical clearance shall be submitted (valid for one calendar year), signed by a medical doctor (nurse practitioners, chiropractors or other non-California licensed medical doctors are not acceptable), stating that the Student has been physically examined and is deemed to be in sufficiently good health and fitness so that the Student may fully participate in Team Activities.

For Physician's Use:

I certify that I examined the above student and found him/her fit to compete in Team activities as follows: _____

Past injuries and physical conditions that should be watched are:

This Medical Clearance shall be valid for one year from the date signed below.

Date

Physician's Signature