This page to be completed by Physician.

Name ______________________________ Date of Physical ____________________

PHYSICIAN RECOMMENDATIONS:

__________**Cleared for all athletic participation**

__________**Conditional Clearance - requires further evaluation prior to participation (see below)**

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__________**Disqualified (see below)**

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Name of Examining Physician:

Address:

Telephone:

Signature of Examining Physician: ______________________________ Date: ______________