Physician Recommendation

Please Complete

1. ❑ Approved for athletic participation ***without*** limitation.

2. ❑ Approved for athletic participation ***with*** limitation.

   Specify: ____
   ____
   ____
   ____

3. ❑ **NOT** approved for athletic participation.

   Specify: ____
   ____
   ____
   ____

Printed Name of Physician: ______________________________

Clinic Name/Facility: ______________________________

Street/City/State/Zip: ______________________________

Phone: ____________________ Fax: ____________________

Signature of Physician: ______________________________ Date ____________________

Medical License #: ______________________________

This form must be signed by an MD or DO.