Lake Stevens School District #4

PHYSICIAN'S AUTHORIZATION TO PARTICIPATE IN SCHOOL ATHLETICS /ACTIVITIES

DATE OF EXAM: _____

STUDENT NAME: _____

DATE OF BIRTH: _____

Age: _____ Height: _____ Weight: _____

ASSESSMENT:

☐ Full Participation – no restrictions

Comments or Recommendations:

_____

_____

_____

_____

_____

EXAMINER'S PHONE: (_____) _____ - _____

CLINIC NAME/ADDRESS: _____

_____

_____

EXAMINER'S NAME (PRINTED OR STAMPED): _____

EXAMINER'S SIGNATURE:

EXAMINER'S TITLE: