Lake Stevens School District #4

PHYSICIAN'S AUTHORIZATION TO PARTICIPATE IN SCHOOL ATHLETICS /ACTIVITIES

DATE OF EXAM: ______________________

STUDENT NAME: ____

Age: ________ Date of Birth: ____ / ____ / _________

Height: __________________ Weight: _________________

ASSESSMENT:

☐ Full Participation – no restrictions

Comments or Recommendations ____

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____

EXAMINER'S PHONE: (_____) _____ - ________

CLINIC NAME/ADDRESS: ____

EXAMINER'S NAME (PRINTED OR STAMPED): _____________________________________

EXAMINER'S SIGNATURE: ____

EXAMINER'S TITLE: ____________