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 _____

_____

_____

_____

_____

_____

EXAMINER'S PHONE: (_____) _____ - _____

CLINIC NAME/ADDRESS: _____

EXAMINER'S NAME (PRINTED OR STAMPED): _____

EXAMINER'S SIGNATURE: _____

EXAMINER'S TITLE: _____