PHYSICIAN’S APPROVAL TO RESUME PARTICIPATION IN INTERSCHOLASTIC ACTIVITIES
(Please Print)

I herewith certify that ___________________________________________ Student Grade

of ____________________________________________________________ School

is physically able to resume practice or play in all high school interscholastic activities at the level of activity indicated below:

_____ Full Participation  ______ Practice Without Contact

_____ Training or Conditioning Only  ______ Other ____________________

Following medical treatment for illness or injury on ______________________ Date

This student:  Must return to me before resuming full participation

Does not need to return to me before resuming full participation

________Date ________ Attending Physician (Print) ____________ Physician’s Signature

NOTE: This signed statement must be filled out by the school before the student resumes participating in interscholastic athletics and cheerleading activities.