

PHYSICAL EXAMINATION

Please have a licensed physician complete the following form or provide another form of documentation from a recent physical examination. Include this with the rest of the application. Please do not have your physician submit it directly.

To be Completed by the Student
Patient's Name: _____
Phone Number: _____
Address: _____ _____
To be Completed by the Physician
I have examined this patient on _____ DATE OF LAST EXAMINATION
I have found the following:
<input type="checkbox"/> They may participate fully in physical activity consisting of cardiovascular, strength, and flexibility training without restrictions or limitations.
<input type="checkbox"/> They may participate in physical activity with the following limitations or restrictions: _____ _____ _____
Physician's Signature: _____ Date: _____
PLEASE NOTE: This record must be signed by the physician granting the clearance.