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**Certification for Sports Participation**

**Year** \_\_\_\_\_

*(To be completed by physician)*

Student's Name \_\_\_\_\_

Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

The above named child had a physical examination on \_\_\_\_\_

Findings were within normal limits and he/she may participate in \_\_\_\_\_  
Sport

\_\_\_\_\_ No restrictions.

\_\_\_\_\_ Some restrictions; \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Family Practice Address