



**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.



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