

ATHLETIC PERMIT

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME _____
Last First Middle Initial Date of Birth

Age ____ Sex ____ Grade ____ School _____ City _____

Present Address _____ Phone _____

Cleared without restriction

Cleared, with recommendation for further evaluation or treatment for: _____

Not cleared for All sports Certain sports: _____

Reason:

Recommendations:

SIGNATURE OF LICENSED PHYSICIAN (MD or DO*) _____

OR APNP: _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Date of Examination _____

**ALL STUDENTS PARTICIPATING DRIFTLESS UNITED ATHLETIC FOOTBALL LEAGUE
MUST HAVE THIS FORM ON FILE AT WITH THEIR COACH PRIOR TO PRACTICE OR
PARTICIPATION.**

**Physicians may authorize Nurse Practitioners or Physician Assistants to stamp this form with the physician's signature or the name of the clinic with which the physician is affiliated.*