6/8/2020

Athletic Participation Form for Athletes with Chronic Medical Conditions

Student Athlete: ________________________________ Date of Birth: __________________________

Sport(s): ____

Diagnosed chronic medical condition(s):
____

I have discussed the risk factors related to COVID19 and athletic participation with the physician treating
my student athlete for the above condition(s).

_________________________ ________________________
Parent’s signature Printed name of parent

____
Date

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TO BE COMPLETED BY PHYSICIAN:

Please check:

______ Student athlete is cleared for participation in the sports listed above without restrictions

______ Student athlete may participate with restrictions: _____________________________________

 ____

______ Student athlete’s medical condition places him/her at greater risk of complications from
COVID19 and therefore he/she should NOT participate in athletic programs until next evaluation

____
Physician’s Signature

____