

*Lake Stevens School District #4*

**PHYSICIAN'S AUTHORIZATION TO PARTICIPATE  
IN SCHOOL ATHLETICS /ACTIVITIES**

DATE OF EXAM: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**ASSESSMENT:**

Full Participation – no restrictions

Comments or Recommendations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

EXAMINER'S PHONE: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

CLINIC NAME/ADDRESS: \_\_\_\_\_

EXAMINER'S NAME (PRINTED OR STAMPED): \_\_\_\_\_

EXAMINER'S SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

EXAMINER'S TITLE: \_\_\_\_\_