



MECKLENBURG COUNTY

Park and Recreation Department

Physician's Statement and Clearance Form

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff of the Therapeutic Recreation Division, Mecklenburg County Park and Recreation related to _____ (participant's name).

All information will be kept confidential.

Parent / Guardian's Signature: _____

Information Requested for: _____ (event)

Date: ____/____/____

Physician's Use Only Certificate of Physical Fitness

To Whom It May Concern:

I concur with my patient's participation in Therapeutic Recreation programs, including the Pop Warner Challenger Flag Football Program, with no restrictions.

I concur with my patient's participation in Therapeutic Recreation programs, including the Pop Warner Challenger Flag Football Program, if she/he restricts the following activities:

I do not concur with my patient's participation in Therapeutic Recreation programs, including the Pop Warner Challenger Flag Football Program.

Reason: _____

Examining Physician (Print): _____

Examining Physician (Signature): _____

Date: _____

By my signature above, I certify that I am a Licensed State Medical Examiner i.e. Medical Doctor, Registered Physician's Assistant or Registered Nurse Practitioner and that I have medically examined the participant named above after January 1 of the current year.