SPS

MEDICAL CLEARANCE FORM

Date ....

Name .... Age .... Sex ....

Class .... Section ....

Height .... Cms. Weight .... Kg.

Specific diseases (if any) :

Suffered in past ....

....

....

Allergies, (if any) ....

....

Any other disease for which child is on regular medication (if any) ....

....

....

Medication Given: ....

....

(Attached Doctor's Prescription)
This individual is physically: (Please check)

- able
- Not able (attach doctor's certificate regarding illness) to participate in Physical Education activities.

Signature / Stamp

Parent's Signature .... Name...

Tel.: .... Examining Physician

.... Tel.: ....