## PHYSICIAN'S CERTIFICATION of PARTICIPANT'S HEALTH

In order to participate in a **sports-related program**, the Physician of a Minor or Counselor in the Program must complete this form. The completed form must be returned to the Program Director. If a physical examination occurred within the last six months, then a copy of the results may be attached. Otherwise a physical examination must be conducted by a licensed healthcare practitioner within six months prior to the program. A physical examination is also required if the individual is currently under medical care, takes prescribed medication, requires a medically prescribed diet, has had an injury or illness during the last six months that limited activity foe a week or more, has ever lost consciousness during physical activity, or has suffered concussion from a head injury.

Participant's Name:			Last 4 digits of SSN:	
Th Ple	e Citadel that may involve st	renuous athletic outdoor activities, history with this person for any	ove will be participating in a program at where the temperature may reach 95°F. interim changes. Please explain any	
1.	GENERAL HEALTH			
	Eyes: Teeth: Heart: Lungs:	Glasses/Contacts: Braces: Nose: Abdomen:	Blood Pressure: Hearing: Skin: Throat: Hernia: Genitalia:	
	Allergies to Medications:			
	Other Allergies (Please specify type and severity):			
2.	MEDICAL HISTORY  Does the individual have chronic medical problems, emotional difficulties, or behavioral issues of which you are aware? [Check one.] YES NO  If Yes, please describe the condition and list prescribed medications and dosing instructions.			
	Recommendations and/or restrictions (e.g., diet, swimming, etc.):			
3.	ACKNOWLEDGEMENT			
	I certify the veracity of the above information.			
	Printed Name of Examining Physician:  Address:			
	City, State, Zip:			
	Signature of Examining P	hysician:		