Medical Clearance from Health Care Provider

Middleburgh Athletics

Parents or Guardians please fill out the information below and then give it to your child's Health Care Provider

I (*Parent/ Guardian name*) _____ give permission for (*Medical Provider*) _____ to indicate whether my child is medically cleared to participate in high-risk interscholastic sports.

Student name: _____

Date of Birth: _____

***Medical Providers** please check the appropriate box and include any additional information. Once completed, please **fax this form to (518) 827 - 5181** or email to mcsathletics@middleburghcsd.org*

Check one of the following:

- ☐ Student indicated above is medically cleared to participate in high-risk high school athletic activities
- ☐ Student indicated above is NOT medically cleared to participate in high-risk high school athletic activities

Additional information:

Health Care Providers	
Medical Provider Signature:	**Date:** Stamp:
Provider Name: (*please print*)	
Office Phone:	