PHYSICIANS RELEASE FORM

(This form is required of any wrestler that has a body fat less than 7% in males and 12% in females in order to be cleared by a physician to wrestle for the 2017-18 school year.)

Section A

(To be completed by the testing Administrator)

Name of wrestler: __________________________ Age: _______ School: __________________

Date of Weight Management Test: __________________ Percent Body Fat: ______

Test Site: ________________________________________________________________

Administrator Signature: _________________________________________________________

Head Coach Signature: ____________________________

__________________________________________________________________________________

Section B

(To be completed by the attending physician)

Name of athlete: _________________________________________ Male _____ Female_____

Date of examination/evaluation: _____________________________

This wrestler has tested under the minimum body fat percentage required by the NFHS and the LHSAA rules. Is it your medical opinion that it is safe for this athlete to wrestle for the 2017-18 school year? YES ______ NO ______

Attending Physician Statement: __________________________________________________________

__________________________________________________________________________________

Attending Physician Name (Print): _______________________________________________________

Attending Physician’s Signature: _______________________________________________________

Date Signed: _________________________

PLEASE SUBMIT THIS FORM WHEN COMPLETED TO
Adam MacDowell, email amacdowell@lhsaa.org
Mail original to: Louisiana High School Weight Certification
3233 Florida Ave. Kenner, Louisiana 70065

Revised 9/22/17
Roberto Furtado