FORM 6
PHYSICAL CLEARANCE

THOMPSON SCHOOL DISTRICT PHYSICIAN CLEARANCE

(REVISED Summer 2021)

Student Name: _____ **Date of Birth** ____/____/____

A. [ ] Cleared

B. [ ] Cleared after completing evaluation/rehabilitation for:

_____

C. [ ] NOT CLEARED:

[ ] Collision [ ] Contact

[ ] Non-contact ____strenuous ____moderately strenuous ____non-strenuous

RECOMMENDATIONS:

_____

_____

_____

EXAMINER NAME: _____

Circle One:

PHYSICIAN PA NURSE PRACTIONER CERTIFIED-REGISTERED CHIROPRACTER

DC-SPC#_____

OFFICE ADDRESS: _____

PHONE: _____

DATE OF EXAM:

_____

SIGNATURE:_____