Lander College for Women

Physical Education Clearance Form

Name: _____

Address: _____

_____

_____

Phone Number: _____

Date of Birth: _____

In Case of Emergency:

Name of Person to Contact: _____

Phone Number(s) Cell: _____

Home: _____

Relationship: _____

To be completed by Physician:

Based on my review of the history and physical examination, _____ may participate in physical education courses and use the exercise facilities.

Limitations/ Special Conditions for Participation:

_____

_____

_____

Allergies (including drug allergies):

_____

_____

_____

Current Medical Conditions:

_____

_____

_____

Pertinent past Medical History: (e.g. Concussion, Fainting, Heat Stroke, Epilepsy/Seizure, Head/Neck Injury, broken bones, Heart Problems)

_____

_____

_____

Additional Medical Information:

_____

_____

_____

Name of Physician (Print) **Date: _____**

_____

Signature **Physician's Stamp**

_____

Address

_____

_____

_____

Phone Number

_____

Registry Number

Please send the completed form to:

Lander College for Women
Office of the Registrar
227 West 60th St.
NY, NY 10023
or fax it to 212- 582- 2344.