Lander College for Women

Physical Education Clearance Form

Name:	Name of Person to Contact: Phone Number(s) Cell:	
Address: Phone Number:		
	Date of Birth:	
	To be	completed by Physician:
Based on my review of the history and physic	cal examination,	
may participate in physical education courses	and use the exercise facilities.	
Limitations/ Special Conditions for Particip	pation:	
Allergies (including drug allergies):		
Current Medical Conditions:		
Pertinent past Medical History: (e.g. Concus	sion, 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 60 th St. NY, NY 10023 or fax it to 212- 582- 2344.		