

**[Provider Name/Clinic Name]**  
[Address]  
[City, State, Zip Code]  
[Phone Number]

**Date:** [Insert Date]

**RE: Medical Clearance for Athletic Participation**

**Patient Name:** [Patient Name]  
**Date of Birth:** [DOB]

To Whom It May Concern,

I have performed a physical examination on the above-named patient on [Date of Exam]. Based on this evaluation, I find this patient to be:

**Cleared for full participation in all sports without restriction.**

**Cleared for participation with the following restrictions/recommendations:**  
[List restrictions or requirements, such as "No contact sports" or "Must use inhaler before exercise"]

**Not cleared for athletic participation at this time.**

This clearance is valid for the current academic year/season unless the patient suffers a new injury or medical condition that may impact their safety during physical activity.

Sincerely,

[Signature of Healthcare Provider]

**[Printed Name of Provider]**  
[Title/Credentials]  
[Medical License Number]