Date: [Date]

To: [College Name] Athletic Department
Attention: Sports Medicine / Athletic Training Staff

RE: Medical Clearance for [Student-Athlete Name]
Date of Birth: [Date of Birth]
Sport: [Sport Name]

To Whom It May Concern,

I have performed a comprehensive physical examination and review of the medical history for the student-athlete named above on [Date of Examination].

Based on my clinical findings, it is my professional medical opinion that the student-athlete is:

[ ] Cleared for full, unrestricted participation in intercollegiate athletics.

[ ] Cleared with the following restrictions/recommendations:
[Insert restrictions here, or "None"]

[ ] Not cleared for athletic participation at this time.

This evaluation included assessments of the cardiovascular system, musculoskeletal system, and neurological health. There are no known contraindications to vigorous physical activity except as noted above.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO/NP/PA]
[Medical License Number]
[Clinic/Hospital Name]
[Phone Number]
[Email Address]

Clinic Stamp: