Date: [Date]

To: [School Name / Athletic Department / Coaching Staff]

Re: Athletic Participation Clearance

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

To whom it may concern,

[Patient Name] has undergone a comprehensive cardiovascular evaluation in my office on [Date of Evaluation]. This evaluation included a review of medical history, a physical examination, and the following diagnostic tests (if applicable): [List tests, e.g., EKG, Echocardiogram, Stress Test].

Based on the results of this evaluation, it is my professional medical opinion that the patient is:

[ ] Cleared for full participation in all competitive sports and physical activities without restriction.

[ ] Cleared for participation with the following restrictions:
[List specific restrictions or conditions here]

[ ] Not cleared for athletic participation at this time.

This clearance is valid for the [Year/Season] athletic season unless there is a significant change in the patient's medical status, such as chest pain, fainting, or palpitations during exercise.

If you have any further questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Board Certification]
[Practice Name/Clinic]
[Contact Information]