Medical Examination

□ I,	(medical doctor/nurse practitioner name) have examined
	(student name) and confirm he/she continues to be symptom free
and is able to return to regular phys	sical education class/intramural /interschool activities in non-contact
sports and full training/practices for	· contact sports.
Medical Doctor/Nurse Practitioner S	Signature:
Date:	

Comments: