

**Central Day School  
Medical Release to Participate in Sports  
2010/2011**

To Whom It May Concern:

This is to confirm that I am a licensed physician and have examined the student listed below for purposes of participation in the athletic program at Central Day School.

Based on my examination, I recommend that he/she be released to participate without any restrictions, or if so, note the following restrictions:

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**Student Information:**

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Student Name	Date of Birth
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Student Address	City/ST/Zip
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**Physician Information:**

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Printed Name of Physician	Physician Phone
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Physician Address	City/ST/Zip
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Physician Signature	Date
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