## PHYSICIAN RELEASE FOR WRESTLER TO PARTICIPATE WITH LESS THAN 7% BODY FAT

Wrestler's Name:	Date of	Exam://
Tester's Verification Signature		
TO THE PHYSICIAN: The wrestler named above has had his b	oody composition tested on the date listed.	
	s a body fat percentage of: is person is restricted to a weight class no lower than	that circled below.
106 - 113 - 120 - 126	- 132 - 138 - 145 - 152 - 160 - 170 - 182 - 195 - 22	20 - 275
	llowable limits by National Federation Rules for the sician's or school wellness center nurse practitioner's is person.	
Your signature below will verify that in will suffer no adverse effects due to par	your best judgment, this wrestler is in good health, i ticipation in the sport of wrestling.	s normally this lean, and
7% (12% for female) and is in good hea wrestling as a result of this low body fat	ove, and verify that this person is normally at a body alth and should suffer no adverse effects due to partic t percentage. He (She) may wrestle at the weight class brough March 15 <sup>th</sup> of the current school year.	cipation in the sport of
Physician Signature	(M.D., D.	O, or Wellness Nurse Practitioner)
Printed Physician Name:		
Office Phone #:		
Office Address:		
Parent Signature	Date:	
Parent Signature	Date:	
	y document accepted as a "Physician's Clearance". I provided to opponent coaches and included with Sta	
FAX a copy of this form to the DIAA, a	at (302)739-1769 or scan to thomas.neubauer@doe.k	12.de.us

Revised/Approved September 2016