DOCTOR'S HEALTH CERTIFICATE

Please have your physician sign this certificate or bring one of your own on or before commencing any NYWA wrestling activity.

I have examined _____ and find him / her physically fit to participate in youth wrestling.

_____
Patient's Age

_____
Patient's Weight

Please provide any heath related information related to the patient that might be important for NYWA and/or its coaching staff to know in the event of an emergency involving the patient, including but not limited to food or environmental allergies.

_____
_____
_____
_____
_____
_____

_____
Physician's Name (please print)

_____ _____
Physician's Signature Date

_____
Street Address City State ZIP

_____
Office Telephone Number