**University of Wisconsin-La Crosse**

**Physical Activity Mentoring Program for Persons with Disabilities**

**Medical Clearance Form-Health Approval to Participate Statement**

On this date, I examined \_\_\_\_\_\_\_\_\_\_\_

Print Name of Participant

On the basis of the examination and medical history furnished to me, this individual may participate in the Physical Activity Mentoring Program for Persons with Disabilities fully or may participate with the limitations noted below.

\_\_\_\_\_\_\_\_ **Cleared; with no physical activity limitations.**

\_\_\_\_\_\_\_\_ **Cleared; with the following physical activity limitations**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_ **Not Cleared**; for the following reason(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Licensed Health Care Provider Date of Examination

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Printed Name of Licensed Health Care Provider Circle: MD/DO/PA/CNP/FNP

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Place of Employment Telephone Number

**Participant or Parent/Guardian sign here:**

Participant (or Parent/Guardian if under 18) Signature Date

**Return to: Physical Activity Mentoring Program Coordinator**

**1725 State St; 108 Mitchell Hall**

**La Crosse, WI 54601**

**608-785-8695 (**[**mentorprogram@uwlax.edu**](mailto:mentorprogram@uwlax.edu)**)**