MINNESOTA GYMNASTICS TRAINING CENTER

Physical Examination Information

Date_____/_____/_____

Name of Participant _____ Age_____ Birthdate_____/_____/_____

Each participant must EITHER attach a copy of a physician conducted sports examination applicable to this current academic year OR have a physician complete and then sign the form below.

Clearance: (circle one)

A. Cleared

B. Cleared after completing evaluation / rehabilitation for:_____

C. Not cleared for: ☐ **Collision**

☐ **Contact**

☐ **Noncontact:** ☐ Strenuous ☐ Moderately strenuous ☐ Nonstrenous

Due to:_____

Recommendation:_____

_____

Signature of physician_____ Date_____/_____/_____

Physician Address_____

Physician Phone_____

Mail to:

MGTC
P.O. Box 41036
Minneapolis, MN 55441

Email to:
mgtcemail@gmail.com