MEDICAL CLERANCE FORM

Participant Information

Participant Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ Zip: _____

Emergency Contact _____ Phone: _____

Medical Information

Diagnosis/Disability:

Medical Problems:

Previous Surgeries:

Allergies:

I AGREE THAT THIS PERSON IS MEDICALLY FIT TO PARTICIPATE IN AN ADAPTIVE OUTRIGGER PADDLING PROGRAM: YES or NO (circle one)

Special restrictions/precautions/recommendations:

Physician Signature: _____ Date: _____

Physician Name: _____ Name of Practice: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____