

PHYSICIANS RELEASE FORM

(This form is required of any wrestler that has a body fat less than 7% in males and 12% in females to be cleared by a physician to wrestle for the 2024-25 school year.)

Section A

(To be completed by the testing Administrator)

Name of wrestler: _____ Age: _____ School: _____

Date of Weight Management Test: _____ Percent Body Fat: _____

Test Site: _____

Assessor Signature: _____

Head Coach Signature: _____

Section B

(To be completed by the attending physician)

Name of athlete: _____ Male _____ Female _____

Date of examination/evaluation: _____

This wrestler has tested under the minimum body fat percentage required by the NFHS and the LHSAA rules. Is it your medical opinion that it is safe for this athlete to wrestle for the 2024-2025 school year? YES _____ NO _____

Attending Physician Statement: _____

Attending Physician Name (Print): _____

Attending Physician's Signature: _____

Date Signed: _____

PLEASE SUBMIT THIS FORM WHEN COMPLETED TO:

- **Adam MacDowell, email amacdowell@lhsaa.org**
- **Mail original to: Louisiana High School Weight Certification**
3233 Florida Ave. Kenner, Louisiana 70065