INABILITY TO PARTICIPATE MEDICAL FORM

Athlete Name:
Athlete Address:
Diagnosis:
History of present Illness/Injury:
Physical Exam findings (include date of assessment):
Investigations (Include dates and results):
Onset of disability:
Anticipated duration:
Name of examining physician:
Address:
Phone number:
Signature: Date:
Reviewed by WCL physician (please circle): Y N

Please forward the signed form to the High Performance Manager. Please note that WCL may request a medical examination by a WCL designated physician.