## PHYSICIAN RELEASE FOR WRESTLER TO PARTICIPATE WITH LESS THAN 7% BODY FAT

Wrestler's Name:	Team
Date of Exam://	Tester's Verification Signature
TO THE PHYSICIAN: The wrestler named above has had his bo	dy composition tested on the date listed.
This test confirmed that the wrestler has a Under DIAA weight loss guidelines, this	body fat percentage of:  person is restricted to a weight class no lower than that circled below.
106 - 113 - 120 - 126 - 132 - 138 - 145	- 152 - 160 - 170 - 182 <b>-</b> 195 - 220 <b>-</b> 275
	wable limits by National Federation Rules for the safety and health of the an's or nurse practitioner's verification that this is an ordinary and normal
Your signature below will verify that in y will suffer no adverse effects due to parti	our best judgment, this wrestler is in good health, is normally this lean, and cipation in the sport of wrestling.
7% (12% for female) and is in good hea wrestling as a result of this low body fat	ve, and verify that this person is normally at a body fat percentage below th and should suffer no adverse effects due to participation in the sport of percentage. He (She) may wrestle at the weight class circled above. This rough March 15 <sup>th</sup> of the current school year.
Physician Signature	(M.D., D.O, or Nurse Practitioner)
Printed Physician Name:	
Office Phone #:	
Office Address:	
Parent Signature	Date:
Parent Signature	Date:
	document accepted as a "Physician's Clearance". Copies of this form shall provided to opponent coaches and included with State Championship

FAX a copy of this form to the DIAA, at (302)739-1769 or scan to diaa@doe.k12.de.us

Revised/Approved September 2020