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 body composition tested on the date listed.

This test confirmed that the wrestler has a body fat percentage of: _____.
Under DIAA weight loss guidelines, this person is restricted to a weight class no lower than that circled below.

106 – 113 – 120 – 126 – 132 – 138 –144 – 150 – 157 – 165 – 175 - 190 – 215 - 285

This body fat percentage is below the allowable limits by National Federation Rules for the safety and health of the participant. The exception is by a physician's or nurse practitioner's verification that this is an ordinary and normal condition for this person.

Your signature below will verify that in your best judgment, this wrestler is in good health, is normally this lean, and will suffer no adverse effects due to participation in the sport of wrestling.

PHYSICIAN'S STATEMENT:
I have examined the wrestler named above, and verify that this person is normally at a body fat percentage below 7% (12% for female) and is in good health and should suffer no adverse effects due to participation in the sport of wrestling as a result of this low body fat percentage. He (She) may wrestle at the weight class circled above. This permission is valid from October 15th through March 15th 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: _____

NOTE to Coaches: This form is the only document accepted as a "Physician's Clearance". Copies of this form shall be attached to your ALPHA Master and provided to opponent coaches and included with State Championship Qualifying event entry materials.

Email a copy of this form to the DIAA, at diaa@doe.k12.de.us

Revised/Approved 2025