STUDENT MEDICAL CLEARANCE FORM

Student Information

Student Full Name:	
Date of Birth:	
Class/Grade:	
Blood Group (if known):	
Known Allergies:	
Chronic Conditions (if any):	
Current Medication:	
Emergency Contact Name:	
Emergency Contact Phone:	

Medical Practitioner Clearance

I certify that I have examined the above-named student and confirm that they are medically fit to participate in normal school activities.

Doctor's Name: _____

Hospital/Clinic: _____

Signature & Stamp: _____

Date: _____