

MEDICAL WAIVER REQUEST FORM

This Medical Waiver Request Form is valid up to 10 days following the first day of try-outs as listed below. At the conclusion of the try-out period, I understand I will either be released from the team or will be given a physical administered by the Cleveland State University Athletic Training Department.

TO BE COMPLETED BY PHYSICIAN:

This is to verify that _____ is in sound medical condition and may participate in vigorous activity required in the sport of _____.

Print Name: Dr. _____ Office Phone: (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Signature of Doctor

Date

TO BE COMPLETED BY STUDENT ATHLETE:

I verify that I assume all responsibility for any injury I may receive while participating in the sport of _____ at Cleveland State University until such time as I am notified regarding my status as a member of the team. I understand this does not affect my rights in case of negligence.

I further declare that I am currently enrolled as a full time (12 hours), degree seeking student at Cleveland State University.

Signature of Student Athlete

Date:

First Date of Try-Outs: _____