I Can Do It, You Can Do It Program

Mentee Name: _____ Program: _____

Approval to Participate Statement

On this date, I examined this individual. On the basis of the examination and medical history furnished to me, this individual may participate in the Overcoming Barriers, or may participate with the limitations noted below.

_____ Cleared; no limitations
_____ Cleared with the following limitations

_____
_____
_____
_____
_____
_____
_____
_____ Not Cleared

_____ _____
Licensed Health Care Provider Signature Date of Examination

_____ Circle: MD/DO/PA/CNP/FNP
Printed Name

_____ _____
Address Telephone Number

Participant or Parent/Guardian sign here:

_____
Participant (or Parent/Guardian) if under 18) Signature Date