TRIBE GYMNASTICS CAMP

PHYSICIAN CLEARANCE FORM

I hereby certify that _____ is physically and mentally able to participate in any or all Tribe Gymnastics Camp activities and that I know of no physical or mental impairments which would in any manner limit her participation in such program.

_____ _____

Physician's Signature Date

License #: _____

Issuing State Medical Board: _____

Office Phone #: _____

THIS FORM CAN BE EMAILED TO WMWGYMNASTICS@GMAIL.COM.