Statement of Medical Clearance for Ready Set Row Camp

Participant's name: _____

Your Physician must complete this form within 3 months of the start of a RSR Camp.

Address: _____

Date of birth: _____

Physician's name: _____

Address: _____

Telephone number: _____

- YES. My patient _____ has been examined _____(date) and has no current unstable medical problems that are a contraindication to participating in an endurance exercise and resistance-training program. I approve of and support her/his full participation in this intense and demanding strength and endurance-training rowing program, where she/he will be rowing and training twice a day. I have discussed the signs and symptoms that would make an exercise program unsafe. These symptoms are summarized as follows:

  _____

  _____

- NO. My patient _____ is not eligible to participate in the Ready Set Row program due to his or her current medical status.

Does your patient have health problems of any kind (including physical, psychiatric, and behavioral) of which we should be aware? _____ NO _____ YES
If yes, please list and/or explain them here:

_____

_____

Please indicate any special recommendations or specific comments:

_____

_____

COVID-19 Infection Medical Clearance

- Date COVID-19 Infection Diagnosed: _____
- If symptomatic, date symptoms resolved: _____

This is to certify that the above-named participant has had a medical assessment for COVID-19 infection to determine return to play clearance in full (not conditionally) and lack of transmissibility to ensure the safety of the rest of the camp.

As the examining LHCP, I have thoroughly assessed the above-named participant (including review of appropriate diagnostic studies, if indicated) and have determined this participant is medically cleared to return to sport with no restrictions. I am aware that she is going to an 4-week overnight intense athletic camp that will be difficult for the athlete to return home or adjust her participation level if she is only conditionally cleared. Therfore, by signing below, I give the above-named participant consent to resume full participation in RSR.

_____ _____

Signature of Licensed Physician, Licensed Physician Assistant, Licensed Nurse Practitioner (Please Circle) Date

_____

Please Print Name

_____

Please Print Office Address Phone Number