

GEORGIA HIGH SCHOOL ASSOCIATION
PHYSICIAN'S CLEARANCE
WRESTLER BELOW BODY FAT ALLOWANCE

Any male wrestler whose body fat percentage at the time of initial assessment is at/or below 7% must obtain in writing a licensed physician's (M.D. or D.O.) clearance, stating that the athlete is naturally at this sub-7% body fat level. In the case of a female wrestler, written physician's clearance must be obtained for athletes who are sub-12% body fat. A physician's clearance is for one season duration and expires March 1 of each school year.

****A \$50.00 appeal fee is required if the coach is seeking approval for a lower weight class than indicated in the assessment.**** See Item C below

WRESTLER'S NAME: _____ GRADE: 9 10 11 12

SCHOOL: _____ AREA: _____

****TO BE COMPLETED PRIOR TO PHYSICIAN'S APPOINTMENT****

<p>DATA REVIEW: Date of initial assessment ___/___/___ Body Fat % _____</p> <p>Initial assessment weight _____ lbs Weight Class _____ (from OPC)</p> <p align="center">EXAMINING PHYSICIAN – ENTER DATA BELOW AT TIME OF ATHLETE'S EVALUATION</p> <p align="center">Date ___/___/___ Weight _____ lbs</p>

Circle A, B or C

- A. The wrestler named has received clearance as provided by the Georgia High School Association Weight Management Program, which is at/or below the 7% (male) or 12% (female) minimum body fat allowance. No Weight Loss. **No fees are required for this option**
- B. The wrestler named is advised to wrestle in a weight class which exceeds the 7% (male) or 12% (female) minimum body fat requirement. **No fees are required for this option**
- C. **APPEAL:** The coach / athlete is requesting approval to wrestle one (1) weight class below his initial assessment. The approved weight class is circled below. **A \$50.00 fee is required for this option**

*****INDICATE APPROVED WEIGHT CLASS – FOR THE OPTION APPROVED*****

103 – 112 – 119 – 125 – 130 – 135 – 140 – 145 – 152 – 160 – 171 – 189 – 215 - 285
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PHYSICIAN'S SIGNATURE _____ DATE _____

ADDRESS: _____

CITY: _____ ZIP: _____

PARENT SIGNATURE: _____ DATE: _____

PARENT SIGNATURE: _____ DATE: _____

NOTE: This form is the only document accepted as a Physician's clearance. The \$50.00 appeal fee must accompany this form when submitted to the GHSA office(Item B).

Mail form to the GHSA, Attn. Gary Phillips, P.O. Box 271, Thomaston, GA 30286.