PHYSICIAN CLEARANCE FOR WRESTLER BODY FAT ALLOWANCE

This form shall be completed and filed with _____ Section, prior **to the athlete competing.**
FAX – 559-781-7033

TO THE PHYSICIAN:
The CALIFORNIA INTERSCHOLASTIC FEDERATION (CIF) has instituted the California Weight Monitoring Program to encourage healthy weight management by interscholastic wrestlers. As part of this program, a minimum weight is established for each wrestler prior to their competitive season. Each wrestler's body fat and lean body mass is measured by a CIF Certified Assessor through BIA measurements. The standard error for this method is ± 4% for higher weights. A minimum weight is then calculated as 7% body fat for males and 12% for females.

Your patient was assessed during the pre-season as less than 7% body fat (or 12% for females). The athlete is requesting that he or she be allowed to wrestle at his or her present weight – (alpha weight). Because this weight is less than 7% (for males) and 12% (for females) body fat, CIF guidelines require permission from the athlete's personal physician. Most adolescents require 5-7% body fat (males) or 10-12% body fat (females) to achieve optimal growth and development. However, there are some adolescents who are naturally lean and develop normally at a lower percent body fat.

Please evaluate your patient for normal growth and development, paying particular attention to weight fluctuations and his or her growth curve. Based on the patient's history and your examination, determine if his/her present weight is compatible with normal growth, development, and good health.

Thank you, Central Section, CIF

Wrestler's name:_____School:_____Grade:_____

DATA REVIEW

Alpha Date: _____/_____/_____ Height:_____ Alpha Weight:_____lbs. Body fat:_____%

Weight class that immediately exceeds the Alpha Weight: _____lbs.

I have examined the above named student-athlete and believe that based on the patient's history, and this examination, that his/her present weight is compatible with normal growth, development, and good health. I therefore approve of this student-athlete's participation at the weight class at or above the Alpha Weight listed above.

PHYSICIAN'S SIGNATURE:_____Date:_____

Print Name:_____
Address:_____City:_____Zip:_____

As the parent or guardian of the above named student-athlete I support our doctor's decision regarding our son's/daughter's participation at the weight class at or above the Alpha Weight listed above.

PARENT SIGNATURE:_____Date:_____

Print Name:_____

As the coach for this athlete I support the doctor's and parent's decision regarding their patient's/son/daughter's participation at the weight class at or above the Alpha Weight listed above.

COACH'S SIGNATURE:_____Date:_____

Print Name:_____

As the principal of the above named student-athlete's high school I affirm that the process of Physician Clearance has been completed properly.

PRINCIPAL SIGNATURE:_____Date:_____

Print Name:_____

High School:_____

Note: **This form is the only document accepted as a "Physician Clearance". Mail or fax a copy of this form to [SECTION].**
Wrestler may not compete until form has been received and posted on the team's "Alpha Master".
Each coach should carry a copy of this Physician's Clearance until the Section Office updates the Alpha Master List.