Wounded Warrior Regiment
1998 Hill Avenue
Quantico, VA 22134

CLEAR FORM

Warrior Athlete Reconditioning Program (WAR-P) MEDICAL CLEARANCE

to be completed by Participant's
PRIMARY CARE PROVIDER

Last Name:_____ **First Name:**_____ **MI:**_____

Rank:_____ **DOB:**_____ **Phone:**_____ **DOD ID:**_____

Allergies: ☐ **NKDA**

Current Medical Diagnoses*:*

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

Current Medications, *to include doseage:*

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

DOES THE PARTICIPANT HAVE ANY SPECIFIC LIMITATIONS TO ACTIVITIES NOT EVIDENT BASED ON DIAGNOSIS LIST? *ie. severe balance issues, open wounds, etc.*

All sports/activities are adaptive and will be customized per patients injury/illness/pain level

Clinician Signature/Stamp:_____

Date:_____ **Email:**_____

Phone Number:_____

Privacy Act Statement *: In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.* ***Principal Purpose(s):*** *This Medical Clearance form is to provide the Wounded Warrior Regiment with a means to use and/or disclose an individual's protected health information in support of Warrior Athlete Reconditioning Program activities.*

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Warrior Athlete Reconditioning Program (WAR-P)
PARTICIPATION CLEARANCE
To be filled out by Medical Provider

Core Sport Offerings:	**Cleared to Participate?**	**Restrictions or Additional Comments:**
Swimming & Aquatics		
Archery		
Cross Country and Track - Run or Wheelchair		
Cycling		
Field Sports (Shot Put/Discus)		
Triathlon		
Rowing - Indoor or Outdoor		
Power Lifting: Bench Press		
Shooting (Air Pistol/Rifle)		
Volleyball - Standing or Seated		
Strength and Conditioning		
Wheelchair/Standing Basketball		
Wheelchair Rugby		

Elective Activities :

Hiking		Horse Related Activities		
Fishing		Hunting		
Yoga		Paddling Sports		
Winter Sports		Rock Climbing		
Baseball or Softball		Scuba Diving		
Golf		Surfing		
Tennis-Standing or Wheelchair				

Additional Notes:

Medical Provider
Signature:_____ **Date:**_____

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