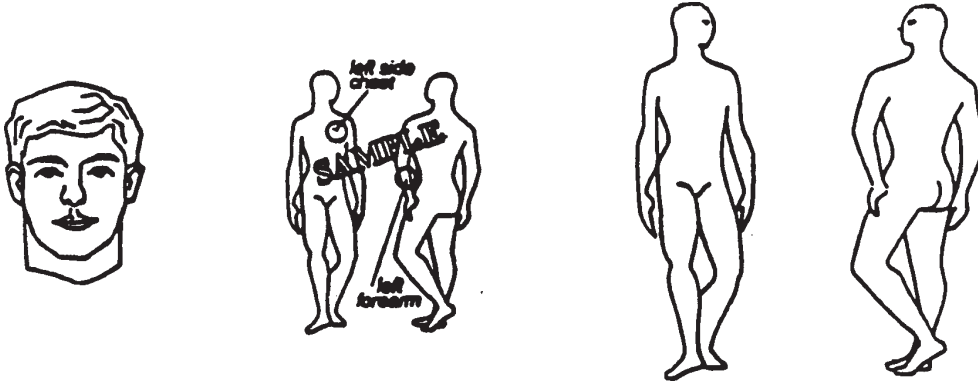


# COMMUNICABLE SKIN DISEASE FORM

ALL MEMBER SCHOOLS are required to process the Communicable Skin Disease form listing the name, grade, and school of any wrestler that desires to return to competition after having been diagnosed as having a communicable skin disease or is suspected of having a communicable skin disease or any other condition that makes participation appear inadvisable.

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Please describe skin condition of \_\_\_\_\_, enrolled in  
(name of wrestler)  
grade \_\_\_\_\_, and a pupil of \_\_\_\_\_ School.

1. Indicate the specific location(s) of the suspected skin condition on the figures below and describe its location(s) (examples: behind right ear; left hand between thumb and index finger).



2. Describe the approximate size and color of the above condition (examples: about the size of a nickel, red in color; about two inches in diameter, blotchy red).

\_\_\_\_\_  
\_\_\_\_\_

3. Technical name of skin condition (diagnosis): \_\_\_\_\_

4. Do you believe the skin condition is contagious or harmful to others? YES NO  
circle one

If yes, is the skin condition under current therapy or has it been treated? YES NO  
circle one

5. If contagious, on what date will the wrestler's participation no longer be harmful to his opponent(s):  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_?

6. The authorization to return to competition expires on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
(Only valid for a maximum of 7 days)

Print Physician's Name \_\_\_\_\_ License No. \_\_\_\_\_

Print Physician's specialty area \_\_\_\_\_

Print Physician's address \_\_\_\_\_  
\_\_\_\_\_

Print physician's telephone number ( ) \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**(Form can be overridden at the Regional and State tournaments by an authorized physician.)**