



6830 Via Del Oro Suite 103, San Jose CA 95119
408-224-2994

**California Interscholastic Federation /Central Coast Section
Wrestling Weight Management Program**

**PHYSICIAN CLEARANCE FORM
WRESTLER BODY FAT ALLOWANCE**

Request to allow wrestler to compete with a body fat of less than 7% for boys and 12% for girls

This form shall be completed and filed with the Central Coast Section Assistant Commissioner Duane Morgan. The athlete may not compete until this form is received and his/her data can be input and the student appears on the school's Wrestling Alpha Master Report and the coach can place the athlete on NWCA Pre-Match Weigh In Form
FAX # 408 224-0476

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 $\pm 4\%$ 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-see below). 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,

Nancy Lazenby Blaser
CIF/Central Coast Section Commissioner

Duane Morgan
CCS Assistant Commissioner

CIF BYLAWS ARTICLE 310

D. Wrestlers Below 7% or 12% Body Fat

Prior to competition, any male wrestler whose body fat percentage at the time of his initial assessment is below 7% may request a waiver in order to establish a certifiable wrestling weight class if a physician attests that the athlete is naturally at his sub-7% body fat level. In the case of a female wrestler, a waiver may be requested if the athlete is naturally at her sub-12% body fat. A waiver form must be signed by a physician, a parent, the principal and the head wrestling coach. The completed waiver form must be mailed or faxed to the appropriate CIF Section office. Wrestlers may not compete at their waiver weight class until the completed waiver form, with all four (4) required signatures, has been received by the appropriate CIF Section office. The waiver weight class is valid for one (1) season only and expires March 15 of each year. The sub-7% male or sub-12% female, who receives clearance, may not wrestle below their actual weight class at the time of initial assessment.

OVER FOR FORM TO BE COMPLETED

**California Interscholastic Federation /Central Coast Section
Wrestling Weight Management Program**

PHYSICIAN CLEARANCE FORM

Wrestler's name: _____

School: _____ Grade: 9 10 11 12

CIF/CCS BIA ASSESSMENT RESULTS

Date of Initial BIA Assessment: ____/____/____

Height _____ Alpha Weight: _____ lbs. Age _____ Body fat: _____ %

Wrestling Weight class that immediately exceeds the Alpha Weight:
103 112 119 125 130 135 140 145 152 160 171 189 215 285

Signature of CCS Assessor: _____

PHYSICIAN'S STATEMENT:

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: _____

PARENTS' STATEMENT

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: _____ Relationship to student: _____

COACH STATEMENT

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: _____

PRINCIPAL'S STATEMENT

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: _____

- This form is the only document accepted as a "Physician Clearance."
- FAX a copy of this form to the CCS Assistant Commissioner Duane Morgan.
- **FAX # 408 224-0476**
- The wrestler **may not compete** until this form is received and his/her data has been entered into the NWCA Web site (allow 72 hours); the student appears on the school's Wrestling **Alpha Master Report**; & the wrestler can print his/her own **Weight Loss Plan**.