2018-2019 St. Bonaventure University
Club Sports Clearance Form

Please place an X next to the sport or sports you wish to play.

<table>
<thead>
<tr>
<th>Men's Teams</th>
<th>Women's Teams</th>
<th>Co-Ed Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>___Basketball</td>
<td>___ Basketball</td>
<td>___ Running</td>
</tr>
<tr>
<td>___Baseball</td>
<td>___ Lacrosse</td>
<td>___ Ski Racing</td>
</tr>
<tr>
<td>___Golf</td>
<td>___ Rugby</td>
<td>___ Field Hockey</td>
</tr>
<tr>
<td>___Ice Hockey</td>
<td>___ Soccer</td>
<td>___ Bowling</td>
</tr>
<tr>
<td>___Lacrosse</td>
<td>___ Softball</td>
<td></td>
</tr>
<tr>
<td>___Rugby</td>
<td>___ Volleyball</td>
<td></td>
</tr>
<tr>
<td>___Soccer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___Volleyball</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date: _____/_____/_________  Grad ___ Senior ___ Junior ___ Soph ___ Fresh ___
Student: ____________________________________________  Gender: Female___
Student Phone: _____________________  Email: ________________________  Male____
Date of Birth: _____/_____/_________

**I agree that the Center for Student Wellness Health Service and Club Sports Staff may contact me via phone call or email.**

SBU Club Sports Student Signature  _____________________________________________________________

St. Bonaventure student _______________________________________________ is CLEARED to participate in Club Sports at St. Bonaventure University during the Fall of 2018 and/or the Spring of 2019 semester.

Printed Provider Name: ____________________________________________________
Provider Signature or Stamp  __________________________________________________
Street Address: _______________________________________________________________________
City, State, Zip Code: _________________________________________________/______/_________

St. Bonaventure student _______________________________________________ is NOT CLEARED to participate in Club Sports at St. Bonaventure University during the Fall of 2018 and/or the Spring of 2019 Semester until further notice.

Reason for non-clearance: _____________________________________________________________

Printed Provider Name: ____________________________________________________________
Provider Signature or Stamp  ________________________________________________________
Street Address: _______________________________________________________________________
City, State, Zip Code: _________________________________________________/______/_________

Please complete and return this form one of three ways:
1. Scan and email: CSWSB@SBU.EDU
2. Fax: 716-375-7892
3. Mail: St. Bonaventure University  
   Center for Student Wellness  
   PO Box 2469 Doyle Hall 127  
   St. Bonaventure, NY 14778

***CELL PHONE PHOTOS OF COMPLETED FORMS ARE NOT ACCEPTABLE***

Please call 716-375-2310 for assistance.

SBU STAFF USE ONLY:    CARL STAFF: _____________    CSW STAFF: ________________  Date: ________________
(Initial after checking the form for completeness and accuracy. Thank you.)

REVISED May 2018, by RD, CA