



**Georgia High School Association
P.O. Box 271
151 South Bethel Street
Thomaston, Georgia 30286
Telephone: 706-647-7473
Fax: 706-647-2638**

**PHYSICIAN APPEAL OF ASSESSMENT
FOR ATHLETES ABOVE 7% or 12% BODY FAT**

TO THE PHYSICIAN:

The Georgia High School Association (GHSA) has instituted a Wrestling Weight Management 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 body composition analysis. A standard error factor of minus 2% has been calculated into the athlete's "lowest allowable weight", as per GHSA policy.

The athlete is requesting that he/she be allowed to wrestle at one (1) weight class lower than noted by the initial assessment. GHSA guidelines require evaluation and permission from the athlete's personal physician for this appeal.

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

Thank you,

The Georgia High School Association

TO GHSA COACHES: Both pages of this appeal are to be presented to the attending physician as a part of the weight class appeal.

GEORGIA HIGH SCHOOL ASSOCIATION

**PHYSICIAN APPEAL
OF MINIMUM WEIGHT CLASS FOR
ATHLETES ABOVE 7% OR 12% ON INITIAL ASSESSMENT**

Fill in top section prior to physician appointment.

WRESTLER'S NAME _____ GRADE 8 9 10 11 12

SCHOOL _____ AREA _____

****The \$50.00 appeal fee must accompany this form when submitted to the GHSA office.
Mail to GHSA, Attention: Denis Tallini, P.O. Box 271, Thomaston, GA 30286.**

DATA REVIEW (from OPC): Date of initial assessment ____/____/____ % Body Fat _____

Initial assessment weight _____ lbs. Weight Class _____ (From OPC)

EXAMINING PHYSICIAN – ENTER DATA BELOW AT TIME OF ATHLETE'S EVALUATION

Date ____/____/____ Weight _____ lbs.

Circle A or B

APPEAL:

- A. After an in office evaluation, the wrestler named has received clearance to engage in a weight loss plan to reach the GHSA weight class circled below. The athlete is given approval to compete in a weight class lower than the initial Assessment [Maximum of One (1) Class Lower].
- B. The wrestler named is advised to wrestle at a weight class at or above the initial assessment. The wrestler is to participate in a weight class **not** lower than the assessment indicated.

****INDICATE APPROVED WEIGHT CLASS [Max One (1) Class Lower]****

106 – 113 – 120 – 126 – 132 – 138 – 145 – 152 – 160 – 170 – 182 – 195 – 220 - 285

PHYSICIAN'S SIGNATURE _____ DATE _____

ADDRESS: _____

CITY: _____ ZIP: _____

PARENT SIGNATURE: _____ DATE: _____

NOTARY SIGNATURE & STAMP _____ **DATE:** _____