



**PHYSICIAN'S STATEMENT FOR  
MISS BLACK IOWA USA & TEEN DELEGATES**  
*To be completed by licensed medical personnel*

Delegate:

Last Name	First Name	Middle Name
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**To the Examining Physician:** The above named delegate has been accepted to participate in the Miss Black Iowa USA Pageant. **Note: This report should be based upon an examination made within six months of the pageant in November 2010.**

Please indicate the existence of the following medical condition(s) which may require medical treatment or support services while participating in the national pageant. *If the answer to any of the following questions is "yes", please give details on the reverse side or on a separate sheet.*

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|--|-----|----|
| 1. Is the applicant seriously underweight or overweight?   | YES | NO |
| 2. Does the applicant have any physical disabilities which might be aggravated through a change of diet, change of climate, carrying her own luggage, or strenuous activities?   | YES | NO |
| 3. Does the applicant have any dietary restrictions?   | YES | NO |
| 4. Does the applicant have any allergies to food or other allergens?   | YES | NO |
| 5. Does the applicant have any history of emotional disturbance?   | YES | NO |
| 6. Are there any existing health conditions that may require treatment during the period of participation in the National competition? If so, what are the condition(s) and what treatment(s) may be required? (Details below)   | YES | NO |
| 7. To your knowledge, does the applicant have any predisposing medical, physical, or psychological factors which may require treatment during the National competition; or that could be exacerbated by the stress of competing? | YES | NO |

If the answer to any of the above questions is "yes", please give details below or on back:

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Physician's Name (Print Clearly): \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Office Address: \_\_\_\_\_

Date Physical Completed: \_\_\_\_\_

**MISS BLACK IOWA USA**  
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