TEAM Survivor

Medical Release Form

Dear ______________________________:

Your patient, __________________________________ (patient name), wishes to participate in a physical activity and training program. Your patient's current goals and proposed physical activity plan are as follows (to be completed by patient):

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Please list any restrictions that you would recommend for this program (to be completed by physician):

Physical limitations: ____

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Medications: ____

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Other restrictions: ____

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___________________________________ (patient name) has my approval to participate in this physical activity and training program with the restrictions described above.

Physician's Signature: _________________________________ **Date:** ___________________
(to be updated annually)

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Participant - Please return completed form at your next program participation, or mail or fax to:

_________________________ (name/company)

_________________________ (addr)

_________________________ (addr)

_________________________ (fax #)