



Medical Release Form

Bring completed forms to your first practice/class or email to info@teamsurvivorsd.org

Part 1 to be completed by *Participant*

_____ **Name** _____ **Address**

_____ CA _____ - _____ - _____
City **Zip** **Phone** **Email**

My current physical activity goals and proposed training plan is:

_____ **Participant Signature** _____ **Date**

Part 2 To be completed by *physician* - Please list any restrictions that you would recommend for this patient for our physical activity and training program

Physical limitations: None Yes (please specify)

Other restrictions: None Yes (please specify)

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

Physician's Name _____ Phone _____
Please Print

Physician's Signature: _____ Date: _____