LEGACY HEALTH | LEGACY CANCER INSTITUTE

Movement Classes at the Legacy Cancer Institute

Physician Release Form

Physician instructions: Give one copy to patient. Original can go in their medical record.

Patient instructions: E-mail the completed and signed form to your instructor. You must review the Form with the instructor *before* your first class.

Patient Name _____ **Date of Birth:** _____

Diagnosis & Stage: _____

Please specify any medical conditions that might limit this individual's participation in this movement class.

Orthopedic problems:

_____

Neurological problems:

_____

Cardiac Status/Limitations:

_____

Cancer or Metastatic Disease/Limitations:

_____

Other:

_____

Please list any movements or activities this individual should avoid (Example: trunk rotation).

_____

I agree that the individual whose name appears above may participate in the Movement for Health and Fitness Class, taking into consideration the above restriction(s):

_____**MD Signature**

_____**MD Print Name**

_____**PHONE**

_____**DATE**