TEAM Survivor CALIFORNIA

Medical Release Form

Please return form to your Program Leader, or send to: **1223 Wilshire Blvd. #570**
phone 310-477-8557 **Fax 310/477-4669** **Santa Monica, CA 90403**

Part 1 to be completed by participant

_____ _____
Name **Address**

_____ CA _____ _____-_____-_____ _____
City **Zip** **Phone** **e-mail**

My current plan for activities and exercise is:

_____

_____

X _____ _____
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. If boxes are left blank we will take this to mean there are no limitations and/or restrictions.**

Physical limitations:

Other restrictions/Comments:

This patient 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:** _____

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