

Stay Strong, Stay Healthy



# Physician Authorization Form

Patient's Name: \_\_\_\_\_ Birth Year: \_\_\_\_\_

Yes, my patient can participate.

Yes, my patient can participate with the following limitations:

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No, my patient cannot participate at this time because of his or her medical conditions and health status.

Physician's signature: \_\_\_\_\_

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

This form may be given to the patient or instructor by fax, email or mail to:

Please return this form by: \_\_\_\_\_

*For instructor use. Valid for one year.*