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:

_____

_____

_____

❑ 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: (Date) _____

For instructor use. Valid for one year.

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