Stay Strong, Stay Healthy

Voluntary 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 their medical conditions and health status.

Physician's signature: _____

Print name: _____ Date: _____

Phone number: _____ Fax: _____

This form may be given to the patient, OR sent to the course instructor at:

Chelsea Richmond, Frontier District, 411 S Oak, PO Box 423, Garnett, KS 66032

Please return this form by: September 29, 2021

For instructor use. Valid for one year.

K-STATE Research and Extension

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