

PHYSICIAN RELEASE

This Form is good for one calendar year

Attention: RHI Sports
Fax: 317-329-2063
Email: rhisports@rhin.com

4141 Shore Drive
Indianapolis, In 46254
317-329-2281

Physician: _____ Phone: _____ Fax: _____

Participants Name: _____ Phone: _____ DOB: _____

Address: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Allergies: _____ Seizures: YES NO

This individual has expressed interest in participating in one or more of the following activities.

- Community Fitness (CF) Competitive Sport _____ Waterski Clinic
(sport)
- During CF they are able to use standing frame.

Please indicate if this individual has medical approval to participate in the above specified activities.
YES _____ NO _____

Please list any contraindication or precautions:

If Patient is currently on any medication that will impact participating in the above listed activity please attach a copy of current medications.

Physician
Comments: _____

Date: _____

Physician Signature _____