PHYSICIAN CONSENT FORM

PHYSICIAN INFORMATION

Physician First Name________________________ Last Name________________________

Hospital____

Hospital Address____

City________________________ State________________ Zip________________

Phone Number________________________ Email________________________

PATIENT MEDICAL INFORMATION

Patient First Name________________________ Last Name________________________

Date of Birth________________________ Phone Number________________________

Parent Email Address____

Hospital Address____

Primary Diagnosis________________________ Date of Diagnosis________________

Secondary Diagnosis________________________ Date of Diagnosis________________

Relapse YES ☐ NO ☐ Date of Relapse________________________

Bone Marrow Transplant YES ☐ NO ☐ Date of Transplant________________________

Any known allergies or other medical conditions________________________________

TREATMENT INFORMATION

Please list all current treatments that could affect participation in Heroes Circle activities.

Heroes Circle activities include jumping jacks, striking soft pads or bags, kicking, and punching. Please note there is **no** body to body contact, **no** sparring, and **no** board breaking.

1. ________________________________
2. ________________________________
3. ________________________________

MEDICAL CONSENT

☐ This child can fully participate in all Heroes Circle activities.

☐ This child cannot participate in Heroes Circle activities at this time.

☐ This child can participate in Heroes Circle activities with the following restrictions: ________________________

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Please sign below to attest that all information entered is complete and accurate to the best of your ability:

Physician Signature________________________ Print Name________________________ Date________________

Fax: 248-864-8245

Tel: 248-864-8238

HeroesCircle.org

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