PHYSICIAN CONSENT FORM

MATIO
KIDS KICKING CANCER

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 **MATIO** activities.

MATIO 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 **MATIO** activities.

☐ This child cannot participate in **MATIO** activities at this time.

☐ This child can participate in **MATIO** activities with the following restrictions: _____

_____

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

MyMATIO.org
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