

Doctor's Release for participation at Break the Barriers, Inc.

_____ is a patient of mine. He/she may participate in (Check all that apply)

Weight & Cardio Equipment/Health & Fitness/Water Aerobics () Yes () No

Yes- may participate with the following restrictions:

Please list any other concerns: _____

Martial Arts: TaekwonDo () Yes () No

Please list any concerns or restrictions: _____

Swimming () Yes () No

Please list any concerns or restrictions: _____

Dance () Yes () No **Aerial Silks** _____ () Yes () No

Please list any concerns or restrictions: _____

Archery () Yes () No **Other** _____ () Yes () No

Please list any concerns or restrictions: _____

Date _____

Print Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone Number: _____

Doctor's Signature: _____