RHI | SPORTS PROGRAM

MOVE UNITED MEMBER

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_____