



MEDICAL RELEASE FORM

Dear _____

Capital of Texas Team Survivor provides health education, exercise and support programs for women cancer patients and survivors in all stages of treatment and recovery. Your patient, _____, wishes to participate in our physical activities and training programs. Your patient's current goals and proposed physical activity plan are as follows (to be completed by patient - circle all applicable program(s)):

Indoor Mall Walking / Outdoor Walking / Bicycling / Yoga / Swimming / Running / Danskin Triathlon Training / Other (please specify):

Are there any restrictions that you would recommend for your patient (to be completed by Medical Care Giver)? Yes / No.

Please explain: _____

_____, (patient name) has my approval to participate in this physical activity and training program with the restrictions described above.

Medical Care Giver's Signature: _____ Date: _____