Kids Kicking Cancer
Power Peace Purpose

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# PHYSICIAN CONSENT FORM 2020

## 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: ________________________________________

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:

________________________________________________________________

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

Physician Signature: ____________________________ Print Name: ____________________ Date: _______________