2018 - 2019 Registration Form

Kids Kicking Cancer
Power Peace Purpose

27600 Northwestern Highway, Suite 220
Southfield, MI 48034
248-864-8238-*tel* • 248-864-8245-*fax*
www.kidskickingcancer.org

PHYSICIAN CONSENT FORM

Physician Information

Last Name_____ First Name_____

Address_____ City_____ State_____ Zip_____

Phone ( ) _____

Patient Medical Information

Last Name: _____ First Name_____ Birthdate: _____ Phone # _____

Primary Diagnosis: _____ Date of Diagnosis _____/_____/_____

Secondary Diagnosis: _____ Date of Diagnosis _____/_____/_____

Relapse: ___no ___yes Date of Relapse _____/_____/_____

Bone Marrow Transplant ___no ___yes Date of Transplant _____/_____/_____

Known allergies or other medical conditions _____

Treatment Information:

List all current treatments that could affect participation in Heroes Circle activities.*

1._____ **4.**_____

2._____ **5.**_____

3._____ **6.**_____

***Activities include jumping jacks, striking soft pads or bags, kicking, punching,**
Note: there is no body to body contact, no sparring and no board breaking

_ _

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:

1) _____

2) _____

3) _____

Physician Signature_____ **Date:** ____/_____/____

Print Name:_____