Functional Exercise Program for Parkinson's Disease: Client Consent and Physician Approval to Exercise

For Patient to Complete

I give my physician permission to disclose information about myself for the purposes described below.

Patient's name _____

Patient's signature _____ Date _____

Physician's name _____

For Physician Use Only

Please complete this form and return to your patient or fax to (224) 521-2597.

Patient's Name: _____

Please check one of the following statements with regard to your patient

☐ My patient is cleared to participate in The Glenview Park District Program: ***Functional Exercise for Parkinson's*** without restriction.

☐ My patient is cleared to participate in The Glenview Park District Program: ***Functional Exercise for Parkinson's*** with the following restrictions or guidelines:

_____

_____

_____

☐ My patient is not cleared to participate in The Glenview Park District Program: ***Functional Exercise For Parkinson's***.

Physician's name (type or print) _____

Physician's signature _____

Date _____

Address _____

Phone _____

Fax _____

Email _____

Thanks very much,

Drew Surinsky, MS, JD, CSCS
niceguytraining@ameritech.net
847-502-0630