



HEALTHCARE PROVIDER CONSENT AND SIGNATURE

Participant Information:

Participant Name: _____ DOB: ____/____/____

Parent/Guardian Name: _____

Home Address: _____
(Street) (City) (State) (Zip Code)

Home Telephone: _____ Office: _____ Cell: _____

To Be Completed By Physician/Physician Assistant/Nurse Practitioner:

Physician Name: _____

Physician Address: _____ Phone: _____

I have examined the above named applicant within the past twelve months. In my opinion, the applicant's condition does not preclude her participation in program activities (most of which will be low to moderate activity)

Date of last exam: ____/____/____

Physician's Signature: _____ Date: ____/____/____

*Other Signature: _____ Date: ____/____/____

* _____ (Initial if completed by R.N. or P.A.)