HOPE AND HEALING HHFC FAMILY CENTER

Before & After Birth Wellness Program

Physician Release Form

Clients Name:_____ Date:_____

Address:_____ City:_____
Zip:_____

Client DOB:___/____/____ Weeks/Trimester:_____

Physician Name:_____ Date:_____

Address:_____ City:_____ Zip:_____

Telephone Number _____ Ext._____

The form serves as a medical release for _____. I have assessed her physical condition and have determined that she is cleared for physical activity. Any limitation or restrictions to physical activity are listed below or can be found on an attachment, which must accompany this document.

Restrictions:_____

_____

_____

_____

limitations:_____
_____
_____
_____

Additional Comments regarding mental health (if none, write NONE)_____

_____
_____
_____

Physician Signature_____ Date_____

Strengthening the Family through Education & Empowerment
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