LivingWell Cancer Resource Center Wellness Programs and Services

Medical Release Form

We are requesting approval for your patient (first and last name) _____ DOB____/_____/_____to participate in our Wellness programs. Please consider the following conditions/limitation, as they *may* be a contraindication for participation in some of our programs and services:

- Limitations with Twisting
- Limitations with Forward or Backward bends
- Weight-bearing Limits
- Inverted Position Limits
- Risk of Falling
- Severe Osteoporosis or other Bone Loss issues
- Lymphedema Concerns

Please check the appropriate boxes below:

Yoga	☐ May participate	☐ Not appropriate at this time
Exercise	☐ May participate	☐ Not appropriate at this time
Facials	☐ May participate	☐ Not appropriate at this time
Reiki	☐ May participate	☐ Not appropriate at this time
Massage	☐ May participate	☐ Not appropriate at this time
Reflexology	☐ May participate	☐ Not appropriate at this time

Please list any concerns that you would like us to be aware of or take extra caution with:

_____

_____

_____ ____/_____/_____
Physician or Health Care Provider Signature Date

_____
(Please print provider name)

_____ ____/_____/_____
Participant Signature Date

_____
(Please print participant name)

Please Send by:

Fax: LivingWell Cancer Resource Center, 630-262-1110

Or Mail: LivingWell Cancer Resource Center, 442 Williamsburg Ave, Geneva, IL 60134

Questions: Please call 630-262-1111