



**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.

The goal of our programs are to support healing, reduce stress and fatigue, and improve sleep.

Classes are designed specifically for cancer patients to improve strength, flexibility, range of motion, circulation and balance; and combat common treatment side-effects such as osteopenia/osteoporosis, lymphedema, neuropathy, and pelvic muscle weakness.

Please check the appropriate boxes below:

(Note: All classes are modified for individuals pre or post cancer treatment)

- | | | |
|----------------------------|--|---|
| Yoga/Exercise | <input type="checkbox"/> May participate | <input type="checkbox"/> Not appropriate at this time |
| Facials | <input type="checkbox"/> May participate | <input type="checkbox"/> Not appropriate at this time |
| Massage/reflexology | <input type="checkbox"/> May participate | <input type="checkbox"/> Not appropriate at this time |

Physician or Health Care Provider Signature

____/____/_____
Date

(Print provider name)

Participant Signature

____/____/_____
Date

(Print participant name)

Please your completed form to:

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