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**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 goals of our programs are to support healing, reduce stress and fatigue, and improve sleep.

Classes are designed specifically to help patients with cancer improve strength, flexibility, range of motion, circulation and balance as well as 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** ☐May participate ☐ Not appropriate at this time

**Facials**  ☐May participate ☐ Not appropriate at this time

**Massage/reflexology** ☐May participate ☐ Not appropriate at this time

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Physician or Health Care Provider Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print provider name)

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Participant Signature Date

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(Print participant name) Participant Phone #

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Participant Email Address

**Please send completed form to:**

·         Email: Living Well Cancer Resources, [info@livingwellcrc.org](mailto:info@livingwellcrc.org)

·         Fax: Living Well Cancer Resources, 630.262.1110