Doctor's Release for participation at Break the Barriers, Inc.

_____ is a patient of mine. DOB_____

He/she may participate in (**Check all that apply**)

Gymnastics ( ) Yes ( ) No

***May use the trampoline ( ) Yes ( ) No**

Yes- may participate with the following restrictions:

_____

Please list any other concerns: _____

_____

Martial Arts: TaekwonDo ( ) Yes ( ) No

Please list any concerns or restrictions: _____

_____

Swimming ( ) Yes ( ) No

Please list any concerns or restrictions: _____

_____

Dance ( ) Yes ( ) No **Aerial Silks** ( ) Yes ( ) No

Please list any concerns or restrictions:_____

_____

Archery ( ) Yes ( ) No **Other**_____ ( )Yes ( ) No

Please list any concerns or restrictions: _____

Date _____

Print Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone Number: _____

Doctor's Signature: _____

8555 N. Cedar Avenue, Fresno CA 93720 (559-432-6292) FAX (559-432-5995)