Capital Region®
SPORTS MEDICINE
An Affiliate of Health Care
Better. Every day.

INJURY PREVENTION PROGRAM
PHYSICIAN CLEARANCE FORM

PHYSICIAN CLEARANCE: I authorize Capital Region Medical Center to contact my physician as stated above, for consent for me to participate in the Injury Prevention Program at Sam B. Cook Healthplex. _____ Please initial if needing consent. Parent or legal guardian must initial if athlete is a minor.

PHYISICIAN NAME: (please print): _____ **FAX:** _____

List restrictions: _____

"Based upon my medical knowledge of this patient and subject to any restrictions listed above, I am unaware of any medical condition that would prelude him/her from participating in an exercise program."

Physician Signature: _____ **Date:** _____

RETURN FAX: 573-632-5990 Mailing address: PO Box 1128, Jefferson City, MO 65102-5634
If you have any questions or would like more information about our services, contact: 573-632-5634