Physician Consent Form

HEROES CIRCLE CANADA
POWER PEACE PURPOSE

PO Box 28036 Oakridge R.O
London, ON N6H5E1
www.kidskickingcancer.ca

Physician Information

Last Name:_____ First Name:_____

Address:_____ City:_____ Prov:_____ Postal Code:_____

Phone:_____

Patient Medical Information

Last Name: _____ First Name:_____ Birthdate: ___/____/_____

Primary Diagnosis: _____ Date of Diagnosis: _____/_____/_____

Secondary Diagnosis: _____ Date of Diagnosis: _____/_____/_____

Relapse: No ☐ Yes ☐ Date of Relapse: _____/_____/_____

Bone Marrow Transplant: No ☐ Yes ☐ Date of Transplant: _____/_____/_____

Known allergies or other medical conditions:

_____

Treatment Information

List all current treatments that could affect participation in Heroes Circle activities*:

1._____ 4._____

2._____ 5._____

3._____ 6._____

*Activities include jumping jacks, striking soft pads or bags, kicking, punching

Note: There is no body to body contact, no sparring and no board breaking

---

Medical Consent

☐This child can fully participate in all Heroes Circle activities

☐This child cannot participate in Heroes Circle activities at this time

☐This child can participate in Heroes Circle activities with the following restrictions:

1) _____

2) _____

3) _____

Physician Signature:_____ Date: ____/_____/____

Print Name:_____