



Marianjoy's 2011 Golf Clinics for Kids!

PHYSICIAN RELEASE

PLEASE NOTE: A signed Physician Release and completed Registration Form are required for each golfer.

Physician's Name: _____

Address: _____

City/State/Zip _____

Phone Number: _____

I, Dr. _____, refer my patient, _____

to participate in Marianjoy Rehabilitation Hospital's Golf Clinics for Kids. I understand that my patient will be working towards building or maintaining strength, flexibility, and balance through various golf exercises and stretches. As part of the program, my patient will be involved with instructional golf clinics as well as short and long course events.

I understand that this patient will be participating in physical activity and has no medical conditions that would contraindicate participation in this program.

Physician's signature

Date

FAX PHYSICIAN'S RELEASE AND REGISTRATION FORM TO: 630-909-8411

For more information, contact

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