Ball Memorial Hospital

Be Well Program

Physician Waiver/Consent

This form must be taken to your personal physician for his or her signature. It must be returned to your instructor after completed. If you choose not to have a physician's consent, please read and sign the physician waiver below.

Physician Waiver

I understand the risks, but I still choose to participate without a physician's consent.

____________________________________ __________________________
Signature of Client Date

Physician Consent

________________________________ is presently enrolled in Indiana University Health Ball Memorial Hospital Rehabilitation Services Be Well Program on _________________, 20____.

This program includes exercises and activities which will increase functional movement, improve muscle tone, increase flexibility, and improve circulation and balance.

_____ Patient has *No Restrictions,* and I recommend his/her participation in the program.

_____ Patient has *Restrictions which include* _______________________________________.
I recommend his/her participation in the program with above restrictions taken into consideration.

_____ I do not recommend this patient to participate in the program.

____________________________________ __________________________
Signature of Physician Date