



MEDICAL RELEASE FORM

Child's Name: _____

Child's Date of Birth: _____

IMPORTANT INFORMATION

This Medical Release Form is valid for one year from the date signed by physician unless hospitalization or other specification is listed below by physician or parent.

The above named person is interested in participating in one or more of the following programs with Kinetic Kids Sports and Recreation Programs.

By checking this box, the child named above is CLEARED TO PARTICIPATE IN ALL Kinetic Kids sports and recreation programs. Any exceptions list here OR mark below: _____.

(Please check ANY EXCEPTIONS.)

- | | | | |
|------------------|-------------------|---------------|-----------------------|
| ___ Baseball | ___ Dance | ___ Karate | ___ Swimming |
| ___ Basketball | ___ Flag Football | ___ Music | ___ Tennis |
| ___ Cheerleading | ___ Golf | ___ Wrestling | ___ Track & Field |
| ___ Crossfit | ___ Gymnastics | ___ Soccer | ___ Wheelchair Sports |

MEDICAL INFORMATION

Primary Diagnoses: _____

Precautions or Restrictions on Activity: _____

Medications Taken Regularly: _____

Adaptive Equipment to Be Considered: _____

Medical or Surgical Procedures Within the Past Year: _____

PHYSICIAN INFORMATION

I have reviewed medical records and history for _____.
Participation in the above noted program(s) is appropriate with the above noted precautions or restrictions.

Physician's Signature

Date Completed

Physician's Address

Physician's Name (Printed)

Physician's Phone Number

**PLEASE RETURN THIS COMPLETED FORM BY FAX TO (210) 558-2021
OR BY E-MAIL TO REGISTER@KINETICKIDSTX.ORG**

***** Parents *** Please be sure to keep a copy of this completed form with your records and always bring a copy to the first day of your child's program.**