Medical Consent Form

To be completed by your physician/healthcare provider

Patient Name: _____ Patient Tel.: _____

Name: _____has my consent to participate in (check which programs):

❑ SoCal Rehab Golf Program ❑ Senior Fitness Class ❑ ABC/Alvarado Balance Class

Please check any of the following precautions that are applicable:

❑ Severe hypotension or hypertension
❑ Severely limited endurance
❑ Medications/anticoagulation
❑ Total hip precautions
❑ Back precautions
❑ Pulmonary
❑ Infectious disease
❑ Other
❑ Recent MI
❑ Severe cardiac disease, cardiac precaution
❑ Allergies
❑ Weight-bearing precautions
❑ Uncontrollable seizures
❑ Syncope/fainting spells
❑ Cognition that would be a safety risk

If checked, please specify: _____

Physician/Healthcare Provider (please print):

_____

Physician/Healthcare Provider Signature:

_____

Date:

_____/ _____/ _____

Physician Tel.:

(_____) _____ - _____

San Diego Rehabilitation Institute
PALS
PROGRAMS FOR ACTIVE LIVING AND SUPPORT

Fax attention to PALS to (619) 229-7161 or email to: YourPals@PrimeHealthcare.com

Alvarado Hospital Medical Center

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