PHYSICIAN REPORT

Parent Authorization

Student Full Name _____

Home Address _____

City/State/Zip _____

Contact Number _____

Birthdate _____ Gender _____

I authorize release of medical information contained in this report to TCMI Academy

X _____

Signature of parent/guardian

Physician Observations: TCMI activities and classes may require strenuous activity. Please provide information on child in the section below.

Child is able to participate in physical activities and classes listed above.
___ Yes ___ No

Comments: _____

_____

_____

_____

Any physical conditions, including vision or hearing impairments, that require special accommodation or attention in school:

_____

_____

_____

Medication prescribed:

_____

_____

_____

_____

Physician Signature _____ Date: _____

TCMI ACADEMY