



# TRUE Nth

## Specialist or Primary Care provider Physical Activity Consent form

Dear: \_\_\_\_\_,

Your patient \_\_\_\_\_ has expressed interest in participating in a cancer specific exercise program developed by the University of Calgary for men with cancer. We ask for your assistance in identifying any contraindications to physical activity.

Please list any additional information you feel is relevant to this particular situation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(To be completed by participant)**

Name: \_\_\_\_\_ | Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_ | Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

I, hereby authorize the City of Kamloops to access any relevant medical information that may pertain to my exercise program. This request will become invalid in 90 days from the date signed

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Note: This recommendation is valid for up to six months following the date of Physician/NP signature. This recommendation becomes invalid if any medical changes occur.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We appreciate your assistance in this matter!

Sincerely,

\_\_\_\_\_

**Please return in person to the Tournament Capital Centre**

**Parks and Recreation department**

910 McGill Road -Kamloops, BC, V2C 6N6 -Bus: (250) 828-3742