Medical Release Form

PATIENT INFORMATION

Patient's Name: ____________________

Patient's Address: ____________________ City/State/Zip: ____________________

Patient's Phone Number: ____________________ Patient's Date of Birth: ____________________

The above patient is seeking medical clearance to the salon and spa services offered by ____________________ , located at ____________________ .

The services are offered to help alleviate unwanted side effects of cancer treatments such as insomnia, muscle spasm, dehydration, hair loss, dry, irritated skin, nausea, anxiety and depression. A qualified salon staff will administer the services as deemed appropriate to include:

- massage
- reflexology
- facial
- waxing services
- nail services
- meditation
- yoga
- replenishing scalp treatments
- ammonia free hair dye
- customized haircut/ shave
- cosmetic services
- acupuncture

If you know of any medical or other reason why the patient's participation in the program would be unwise, please indicate so on this form.

By completing the form below, however, you are not assuming any responsibility for our administration of Mondays at Racine salon services.

If you have any questions about the Mondays at Racine program, please call the program headquarters and speak with

TO BE COMPLETED BY PHYSICIAN

Please write legibly and choose one.

☐ I recommend the patient NOT participate.

☐ I know of no reason why the patient may not participate.

☐ I believe the applicant can participate, with exception of the following services: ____________________

Physician's Name: ____________________

Physician's Signature: ____________________ Date: ____________________

Address: ____________________ City/State/Zip: ____________________

Contact Number: ____________________

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