WELLFLEET ADULT COMMUNITY CENTER
715 Old King's Hwy., Wellfleet, MA 02667
508-349-2800 or 508-349-0313
fax: 508-349-0319

PHYSICIAN'S APPROVAL FORM

The following section is to be completed by participant (form is valid for one calendar year from doctor's dated signature):

Physician Name and fax # _____

Contractual agreement:

I, _____, understand I will be participating in a physical exercise activity at the Wellfleet Adult Community Center or designated locations. I am responsible to inform the staff of my health status each session. If symptoms of distress, chest pain and/or other ailments are present, I understand that I will not be able to participate that given day. In addition, I hereby release the Town of Wellfleet, its affiliates, and employees, from any liability whatsoever occasioned by my participation in the program, including, but not limited to, my participation in field trips. I also authorize the Town of Wellfleet, its affiliates, and employees to call for medical assistance on my behalf if they deem it necessary.

Signed:_____ **Date:**_____

Print Name: _____ **Phone:**_____

Address: _____ **D.O.B.**_____

***Email:** _____

Emergency contact: _____

Relationship: _____ **Phone:**_____

Please select exercise program:

☐ Tai Chi ☐Yoga ☐Sit & Fit ☐Walking Group ☐Aqua

The following section is to be completed by Physician:
The above patient may participate in a physical activity at the Wellfleet Council on Aging, based on the most recent medical information at my disposal.

Signed: _____ **Date:** _____
(Primary care physician)

Print: _____

This form may be faxed back to the COA number indicated above.

May 2023