

**Moving Miracles, Inc.**



**PHYSICIAN STATEMENT AND  
MEDICAL RELEASE FOR  
PARTICIPATION**



Your patient, \_\_\_\_\_, is interested in participating in a dance/movement program at Moving Miracles, Inc. Kindly confirm whether you approve of your patient's participation in a dance program and/or whether you recommend any limitations in this activity.

\_\_\_\_\_ This patient may participate in this dance program without restrictions.

\_\_\_\_\_ This patient may participate in this dance program with the following restrictions: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Print Physician's Name

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Physician's Phone Number

Dated: \_\_\_\_\_

Moving Miracles Inc.

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