

# Physician's Approval Form

\_\_\_\_\_ has a medical approval to participate in a general relaxation massage.

**The following restrictions apply (if none, so state):**

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

**Medications:**

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

\_\_\_\_\_  
**Physician's signature**

\_\_\_\_\_  
**Physician's name**

\_\_\_\_\_  
**Street Address**

\_\_\_\_\_  
**City**

**State**

**Zip Code**

**Phone** \_\_\_\_\_

**Fax** \_\_\_\_\_

**Date** \_\_\_\_\_