PRAIRIE YOGA / ALIGN YOUR SELF®

Physician's (or Health Care Provider's) Medical Release For Yoga Classes

We are requesting approval for your patient _____
(Patient Name)

to participate in yoga and other fitness programs at Prairie Yoga.

_____ May Participate

_____ May NOT Participate

Please list any limitations or contraindications:

_____

_____

_____

_____

_____

_____ _____
Physician or Health Care Provider Signature Date

_____
(Please print physician's name)

Please send this form to Prairie Yoga by:

Email: prairieyoga@comcast.net

OR

Send/Drop off to: Prairie Yoga, 4701 Auvergne Avenue | Suite 104 | Lisle, IL 60532