



4500 Steilacoom Blvd SW
Lakewood, WA 98499

Medical Statement For: _____
(Student name)

Program Start Date: _____

CONFIDENTIAL



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Confidentiality Release for Medical/Health Information

I _____ do hereby give my permission to release my medical information to the instructors and staff of Clover Park Technical College for the purpose of admission into the Massage Studies program. In addition, I give my permission for the instructors to contact the Physician who has completed my medical statement for program entry as needed for clarity or further information. I understand that this disclosure is to ensure my physical safety and participation during the course.

Release will expire 90 days after date signed below

Physician:

Name: _____

Address: _____

Phone: _____

Date: _____

Student signature: _____

Witness: _____



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Dear Doctor,

Your patient wishes to enter the Massage Studies program at Clover Park Technical College. This program is both physically and mentally challenging. The student must be able to:

- Lift 10-30 pounds safely
- Stand and perform massage 1-2 hours at a time
- Sit in lecture class for numerous hours each day
- Receive massage and bodywork, including deep tissue, on a regular basis.

Due to tissue compressions, transient rise in blood pressure and increased venous return volumes, there are several conditions in which massage therapy may be contraindicated for a student.

**Please check all conditions that are of concern for this individual*

- Previous or current disc problems/conditions
- Vascular disease/condition
- Hypertension
- Systemic inflammatory condition (please specify)

- Arthritis
- Cancer
- Diabetes – Type 1 or type 2
- Mental instability
- Infectious disease
- Current injury (please specify)

Please list or attach current medications:

To the best of your knowledge, do you believe this student will be able to participate safely and fully in this demanding program? _____ yes _____ no

Physician's signature: _____ Date: _____

Address: _____ Phone: _____

Thank you.