



Health Care Provider Form

If you answered YES to one or more questions on the Health Status Questionnaire section of the Parent Consent Form, please have your physician complete the information below and mail the

completed Statement of Informed Consent, Assumption of Risk, and Release form and the Parent Consent Form and the Health Care Provider Form using the enclosed, postage-paid

envelope by first week of June, if possible, or before the first day of class.

Dear Health Care Provider:

The College of Southern Maryland requires that _____ provide a medical release to participate in _____. Concern has been raised by the individual's response on a self-evaluation of his/her health status. The individual can provide you with a copy of that self-evaluation and the course/activity description.

If you require further information about the activity, you may contact:

Program coordinator for sports, 301-539-4840, and/or Program coordinator for academic enrichment, 301-934-7645.

Please note that the individual will not be able to participate until this release is provided to the instructor of the class.

Following consultation with the above-named individual regarding the specified activity, please check one of the following:

This individual can safely participate in this activity without restriction.

This individual can safely participate in this activity with the following restrictions:

This individual cannot participate safely in this activity.

SIGNATURE OF LICENSED HEALTH CARE PROVIDER

DATE

ADDRESS

Child's Name

Course Number/Name