MEDICAL CLEARANCE FORM

8th Annual National Wounded Warrior Tennis Camp
Balboa Tennis Club, San Diego, CA, May 5-11, 2019

This camp provides 16 hours of tennis instruction over four days plus evening outings.
More information about this camp is available at www.sdwoundedwarriortennis.org
Camp POC: Steve Kappes, **Phone**: 619-948-4596, **Email:** stevekappes@hotmail.com.

Please obtain approvals from your current primary care physician and therapists, as well as your chain-of-command if on active duty.

Applicant's Name: _____ Phone_____
Unit if active duty: _____

PRIMARY CARE PHYSICIAN'S AUTHORIZATION (REQUIRED)

Name of Primary Care Provider: _____ Phone_____

Hospital/Clinic Mailing Address: _____

Primary Care Provider Signature: _____ Date: _____

MENTAL HEALTH THERAPIST'S AUTHORIZATION (if applicable)

Name of Mental Health Therapist: _____ _____ Phone_____

Hospital/Clinic Mailing Address: _____

Mental Health Therapist's Signature: _____ Date: _____

RECREATION THERAPIST'S AUTHORIZATION (if applicable)

Name of Recreation Therapist: _____ Phone_____

Hospital/Clinic Mailing Address: _____

Recreation Therapist's Signature: _____ Date: _____

PHYSICAL THERAPIST'S AUTHORIZATION (if applicable)

Name of Physical Therapist: _____ Phone_____

Hospital/Clinic Mailing Address: _____

Physical Therapist's Signature: _____ Date: _____

CHAIN-OF-COMMAND AUTHORIZATION (if active duty):

Name of Officer-in-Charge: _____ Phone_____

Command address: _____

Officer in Charge Signature: _____ Date: _____