

## The Team Unbreakable Youth Running Therapy Program

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### Medical Clearance Form

I Dr. \_\_\_\_\_ (print name),

have examined

\_\_\_\_\_ (print patient name)

and find that he/she is in good health and therefore able to participate in The Team Unbreakable Youth Running Therapy Program operated by:

\_\_\_\_\_

(Insert Organization name above)

About the program: This is a thirteen week running program that enables participants to learn through experience, workshops and presentations. Participants learn how to run utilizing commonly available learn how to run programs, which culminates in week 13 with a 5K run

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please print or use stamp - Dr. Name & contact information:

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