



WCKI Medical Clearance Form



We Can Kick It (WCKI) is a nonprofit charity that uses the passion of soccer to empower those affected by cancer by offering free events and programs to the families within our network.

Participant Information

First and Last Name: _____

Date of Birth: _____

Medical Institution Name: _____

Physician's Name: _____

Physician's Phone Number: _____ Ext: _____

Please email completed form to info@wecankickit.org or upload with your [online Goal Getters application](https://wecankickit.org/pages/goal-getters-application) (<https://wecankickit.org/pages/goal-getters-application>).

Physician Assessment

Dear Dr. _____ ,

Your patient, _____ ,
has requested to participate in the WCKI Goal Getters program.

The Goal Getter program is a 12-week one-on-one program that aims to increase a child's strength, mobility, and confidence while having a fun time learning to play soccer. The program is tailor-made for each participant's skill, ability, and comfort level, allowing us to review and assess achievements throughout the 12-week program. Our qualified soccer coach creates an individualized curriculum for each child that matches their needs and objectives. We have designed the Goal Getters to start with easy exercises and simple skill-building routines. As the program progresses, the activities gradually become more challenging. Each weekly session last from 30 minutes to an hour.

You **are not** assuming any responsibility for the program's administration by completing the WCKI Medical Clearance Form. However, if participation in the Goal Getters program would be unwise for this patient due to medical or health concerns, please indicate your professional opinion on the Physician's Report below.

If you have any questions or concerns regarding WCKI or the Goal Getters program, please do not hesitate to Roz McMahon at 347-543-4529 or email roz@wecankickit.org. To learn more about what we do and how we serve, we please www.wecankickit.org.

Physician's Report

My patient, listed above, is:

- Not cleared to exercise at this time
- Cleared to exercise at this time with no restrictions
- Cleared to exercise with the following restrictions and recommendations:

Physician Signature: _____ Date: _____

Physician Printed Name: _____