Physician's Release for Pediatric Massage Therapy

(to be filled out by parent/guardian and child's physician)

Your patient's caregiver,_____, has requested pediatric massage

therapy for your patient _____.

Please verify your clearance for the patient to receive massage therapy, while indicating any limitations, by your signature below. This release can be modified/withdrawn at any time, should your patient's health status change, by contacting Autumn Woodward at the address below. Thank you for your time and assistance!

Child's healthcare status: □ normal progression □ high risk □ complications (detail below)

Massage that is appropriate for patient's condition:

- ☐ Full body, circulatory/Swedish massage
- ☐ Local massage only – avoid full body circulatory massage
- ☐ Massage appropriate, avoid the following areas:_____
- ☐ Any/all massage is cleared

Specific limitations or precautions for massage therapy:

Massage therapist may contact me directly for clarification or concerns regarding this patient. Yes /No

Healthcare Provider Contact Information:

Name: _____ Phone:_____

Signature:_____ Date:_____

Massage Therapist Contact Information:

Autumn Woodward, MA, LMBT
Licensed Massage Therapist
NC License #3585

47 Orange St., Suite C
Asheville, NC 28801
Phone: 828-333-7315

autumn@autumnwoodward.com
Website: autumnwoodward.com