FLORIDA DEPARTMENT OF JUVENILE JUSTICE

Protective Action Response Medical Release

Date Completed: _____/_____/_____

Title of Office or P.A.	Patient's Name (Please print.)
Professional Address	Date of Examination
	Physician's Name (Please print.)
	Physician's Signature
	License Number
	Licensing State

The patient identified above is being released from the restrictions identified on the patient's Medical Status form. This patient can now perform all of the Protective Action Response techniques.