Medical Release For Client To Exercise

Date _____

Dear Doctor_____:

Your patient, _____, wishes to start a personalized training program. The activity will involve the following:

Type:_____

Frequency:_____

Duration:_____

Intensity:_____

If your patient is taking medications that will affect his or her exercise capacity or heart-rate response to exercise, please indicate the manner of the effect (raises or lowers exercise capacity or heart-rate response):

Type of medication(s):_____

Effect(s): _____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

_____

_____

_____

Thank you.

Sincerely,

Print name:_____

Address:_____

Phone:_____

E-mail:_____

_____ has my approval to begin an exercise program with the
(Patient's name)

recommendations or restrictions stated above.

Signed_____ Date_____ Phone_____
(Doctor's signature)

ACE