MEDICAL RELEASE FORM

Date _____

Dear Doctor:

Your patient,_____, wishes to start a personalized training program. The activity will involve the following (type, frequency, duration, and intensity of activities):

_____

_____

_____

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,

Heather Stover, Office Manager

_____ has my approval to begin an exercise program with the recommendations or restrictions stated above.

Signed_____Date_____Phone_____

Integrated Fitness of Dover
44 Dover Point Road, Unit H, Dover, NH 03820
603-343-5920

INTEGRATED FITNESS of Dover