Medical Release Form

Date___________________

Dear Doctor ____________________:

Your patient __________________________, wishes to start a personalized training program.

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers or has no effect on heart rate response during exercise):
· Type of medication: ____
· Effect: ____
· Type of medication: ____
· Effect: ____

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

Thank you.

Sincerely,

Personal Trainer
2736 Medina Rd Medina, Ohio 44256
330-591-0772

Physician completes:
_________________________________ has my approval to begin an exercise program with the recommendations or restrictions stated above.
Signed________________________________ Date_____________