## Medical Release Form


Please have your physician fill out this medical clearance form. Once the personal trainer has received this form you may begin your health and fitness program.

Date _____

Patient Name _____

Dear (Doctor Name)

_____,

Your patient wishes to start a personal training program. However, based on their responses to the health history questionnaire and/or risk assessment the trainer has requested they receive medical clearance before the program can begin.

If your patient is taking medications that will affect his/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).

**Types of medication**

_____

_____

_____

**Effect(s)**

_____

_____

_____

**Please identify any medications that could increase your patients risk for problems while exercising**

_____

_____

_____

**Please identify any recommendations or restrictions that are appropriate for your patient in his exercise program**

_____

_____

_____

_____

Thank you.

Sincerely,

Christy Andorf – Wellness Coordinator
Champions Recovery Room and Physical Therapy LLC
3030 100th St. Urbandale, Iowa
(515)410-2908

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

Signed

_____

Date _____ Phone _____