

Medical Release Form

Your patient, _____, wishes to start a personalized training program. The activity may include a fitness assessment and an exercise program involving cardiovascular endurance, muscular strength and endurance, and flexibility.

Medications

If your patient is taking medications that will affect his or her heart rate response to exercise, please indicate the manner of the affect (raises, lowers, or has no affect on heart rate response).

If your patient is taking any medication that will affect blood sugar, sense of balance, or have any other affect with response to exercise, please indicate the medications and the manner of the affect.

Type of medication	Affect
_____	_____
Type of medication	Affect
_____	_____
Type of medication	Affect
_____	_____

Recommendations and Restrictions

Please identify any recommendations or restrictions for your patient in this exercise program.

Approval

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

Name of physician

Signature of physician

Address

Phone number

Email address

Date

Please return this form to your patient or to Shannon R. GaNun, 140 Windsong Drive, Richmond Hill, GA 31324.

I, _____, hereby authorize the above named physician to release the information requested on this form to Shannon R. GaNun for the purpose of designing an appropriate exercise program.