

# Medical Release Form

Date \_\_\_\_\_

Dear Doctor \_\_\_\_\_:

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

- Exercise type:
- Exercise frequency:
- Exercise duration:
- Exercise intensity:

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,

Mary Catherine Domaleski  
Personal Trainer  
295 Magmar Lane, Fayetteville, GA 30214  
(678) 464-9021

*Physician completes:*

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

Signed \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_