



Medical Release for Client to Exercise

Date _____

Dear Doctor _____:

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

Type: _____

Frequency: _____

Duration: _____

Intensity: _____

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, lowers, or has no effect on 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,

Print name: _____

Address: _____

Phone: _____

E-mail: _____

_____ has my approval to begin an exercise program with the
(Patient's name)
recommendations or restrictions stated above.

Signed _____ Date _____ Phone _____
(Doctor's signature)