Medical Release Form

Date _____

Dear Doctor:

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

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 or lowers 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,

Kelly Pope

Kelly Pope Fitness and Massage

1206 E. Waterman

316-619-5606

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

Signed _____ Date_____ Phone_____