

Medical Release Form

Date _____

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

(type, frequency, duration, and intensity of activities)

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

Type of medication _____

Effect _____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

Thank You.
Sincerely,

Ryan M. Stachelek
Repetitions
Address
Phone

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

Signed Date Phone