

Fitness Solutions



www.n2fitness-solutions.com

MEDICAL RELEASE FORM

Your Patient: Mr./Ms. _____ wishes to start a personalized exercise training program.

The activity will involve the following: (type, frequency, duration and intensity of activities)

Mr. / Ms. _____ will be partaking in strength, conditioning, flexibility & core training activities _____ times per week that will engage the entire musculoskeletal structure through the use of resistance exercises, Pilates repertoire, as well as trunk / abdominal and spinal stabilization exercises. In addition, Mr. / Ms. _____ intends to engage in cardiovascular activities _____ times per week using a stationary treadmill, up-right stationary bike, and the like.

His / Her exercise program will be designed and implemented to encourage a safe and progressive physiological response so that his/her functional wellness and ability to engage in activities of daily living are brought to improved levels.

If your patient is taking medication that will affect 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 as part of this exercise program:

Thank you,

Keith Dougherty
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American Council on Exercise
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Mr. / Ms. _____ has my approval to begin an exercise program with the recommendations or restrictions stated.

Signed _____ Date _____ Phone _____