<u>Medical Release</u>

Date: ______________________

Dear Doctor: ____

Your patient____ wishes to start a personalized training program. Which if any activities should be eliminated from the above participant specialized program (weight lifting, running, lunging, squatting, and or group exercise classes):____

____

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 you patient in starting an exercise program:

____

____

Thank you.

Sincerely,

Mariah Prussia

Xtreme Measures
Women's Fitness Facility

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

Signed:____Date:_____________

Phone: ____