Medical Release

Date: _____

Dear Doctor,

Your patient _____ wishes to start a personal fitness training program which will include the following activities:

Strength training with machines and free weights, cardiovascular exercise and conditioning, core, stability & balance work along with stretching.

1) Is the patient on any medications that will affect their performance, balance, weight loss or heart rate response to exercise?

Type of medication(s):_____

Condition(s): _____

Effect(s): _____

2) Are there any signs or symptoms that would indicate a need for referral back to a physician?

_____

_____

3) Has the client had any recent surgeries, treatments or invasive procedures?

_____

_____

4) Is there any other unassociated medical/health conditions?

_____

_____

5) Are there any recommendations or contraindicated exercises?

_____

_____

_____

6) Is there an initial or long-term limitation on strengthening, loading or in range of motion the muscles, joint(s)/ spine that can be worked through strength training, stretching, or cardiovascular exercise?

_____

_____

_____

7) What is your long-term health/wellness goals for this patient?

_____

_____

_____

Please feel free to contact us personally to discuss any particulars that might be important, as my goal is for your patient to have a successful experience. Thank you.

Sincerely,
Lisa Dougherty
MedFit at Gratitude Ranch (gratituderanch.org)
(949) 346-1734
lisa@medfitfoundation.org

_____ has medical approval to participate in fitness activities and exercise programs with the recommendations or restrictions stated above.

_____ _____

Physician's Signature Physician's Address

_____ _____

Physician's Name Physician's Phone