Medical Release

Date 2/26/15

Dear Doctor:

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

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

Type of medication_____
Effect_____
Please identify any recommendations or restrictions that are appropriate for your Patient in this exercise program_____
_____
_____

Thank You
Sincerely,

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

Signed _____Date_____ Phone_____