Medical Release Form – Post Rehab

Dear Doctor:

Mr., Mrs., Ms._____ wishes to start a personalized fitness training program to maintain optimal health and improve fitness. All activities will follow current ACSM guidelines and will be overseen by a certified trainer who has a Master of Science degree in Kinesiology. The activity may include the following depending on their goals and abilities:

Fitness Assessment to include sub-maximal aerobic evaluation
Moderate aerobic exercise
Moderate strength training
Flexibility exercises
Balance exercises

If your patient is taking medications that will affect their balance or their heart rate response to exercise, please indicate the manner of the effect:

medication_____

effect_____

Please indicate diagnosis / reason for referral:

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

Would you like to receive progress reports regarding your patient's exercise program? Yes No

Monthly Every 3 months Every 6 months Annually

If yes, how would you prefer to receive progress reports?
__ phone (list number) _____
__email (list email address) _____
__ fax (list number) _____
__ US mail (list address) _____

Physician Name (please print)_____

Physician Signature_____ Date_____

Phone_____

Please direct any questions about this program to:
Kelly Doyle, MS, CSCS
K's Body Shop Personal Fitness Training
(612)804-9496
kdoyle@ksbodyshop.com

Please return this completed form at your earliest convenience to your patient, who can then present it to their trainer during the initial evaluation.