



Date: _____

To Physician:

Your patient _____ wishes to start a personalized exercise training program. The activities involve the following:

Type of Activity: Time/Duration/Intensity:

Cardiovascular: _____ -

Resistance Training: _____ -

Flexibility: _____ -

Other: _____

Additional Notes:

-

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

Please list any medications that your client is currently taking which would impact exercise:

If your patient is taking medications that will affect their heart rate response to exercise, please indicate any effect (raises, lowers, has no effect on heart rate response):

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

Physician's Signature:

Print Name:

Date:

Phone:

Thank you for taking the time to fill this out.