

PERSONAL TRAINING PROGRAM PHYSICIAN'S RELEASE

Dear Doctor:

Your patient, _____, wishes to start a personalized training program through the North Dakota State University Wellness Center. Exercise recommendations provided by the trainer will start easy and become progressively more intense depending on the client's goal and fitness level. Qualified staff will administer all fitness assessments and exercise.

If you know of any medical or other reasons why participation in the program by the client would be unwise, please indicate so on this form.

Report of Physician

_____ I know of no reason why the applicant may not participate.

_____ I believe the client can participate, but I urge caution because:

*My patient is taking medications that will affect heart rate response to exercise. The effects are indicated below:

Type of medication _____

Effect _____

Restrictions for exercise _____

_____ The client should not engage in the following activities:

_____ I recommend that the client NOT participate.

Physician Signature: _____

Date: ____/____/____

Print Name: _____

Phone: _____