Physician Medical Release Form

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Date: _____/_____/_____

Doctor's Name:_____

Your patient, _____, DOB _____/_____/_____wishes to participate in the Day One Fitness (High-Intensity) exercise program. The activity will involve cardiovascular training (jumping rope, running, punching heavy bags), flexibility instruction (stretching, getting up and down on the floor), resistance training and core strengthening techniques. Participants can attend up to five classes per week that are up to 90 minutes in duration. Participants can reach up to 90 percent of their maximum heart rate.

PHYSICIAN'S RECOMMENDATION

☐ I am not aware of any restrictions to participate in this exercise program.

☐ I believe the patient can participate but would urge caution (*please explain*): _____

_____

☐ Patient should not engage in the following activities:

_____

_____

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

Type of medication _____ Effect_____

Type of medication _____ Effect_____

Type of medication _____ Effect _____

PHYSICIAN COMPLETES

I confirm that _____ (patient's name) has been diagnosed with (Alzheimer's Disease, Parkinson's Disease, Stroke, or other), and has my approval to begin the non-contact boxing exercise program with the recommendations or restrictions stated above.

Printed name _____ Phone _____

Signature _____

RETURN TO

Day One Fitness
257 Beech Island Ave
Beech Island, SC 29842

Phone: 803-265-1699 info@dayonefitness.org