Sans Souci Massage & Wellness Center LLC

Katherine Schimmel LMT, CFT

Medical Release

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has enrolled in an adaptive fitness program. This program involves individualized exercise programs (with or without assistance) for improvements in muscular strength, range of motion, cardiovascular endurance, posture, and balance. In order for the instructor to provide a safe and beneficial program, it is requested that you examine the individual to determine his/her eligibility to participate in the named activities. It is also requested that you provide any medical information which would affect the selection of activities. Physician’s recommendations and limitations have been most helpful with past programs. All medical information will be handled in strict confidence. Thank you for your cooperation.

Physician to Complete the Following:

It is my understanding that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will be participating in a fitness evaluation and exercise program. This patient is permitted to participate in the following activities. *(Please check all that apply.)*

1. Comprehensive physical fitness assessment including:

\_\_\_\_\_ submaximal aerobic capacity test for cardiovascular endurance

\_\_\_\_\_ resting heart rate, resting blood pressure

\_\_\_\_\_ body composition analysis

\_\_\_\_\_ flexibility

\_\_\_\_\_ baseline upper and lower body strength measures

\_\_\_\_\_ baseline upper and lower body endurance measures

other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Exercise/rehabilitation program including:

\_\_\_\_\_ resistance exercise program

\_\_\_\_\_ cardiovascular exercise program

\_\_\_\_\_ nutritional recommendations

other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the appropriate response:

\_\_\_\_\_ This patient may participate with no restrictions.

\_\_\_\_\_ This patient may participate with the following limitations:

\_\_\_\_\_ This patient may not participate. *(If checked, the individual will not be accepted.)*

Other:

Diagnosis/Recommendations/Comments:

PHYSICIAN NAME *(please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

PHYSICIAN SIGNATURE DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARTICIPANT NAME *(please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

PARTICIPANT SIGNATURE DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_