MEDICAL RELEASE FORM

Date _____

Dear Doctor:

Your patient, _____, wishes to start a personalized training program.

However, your patient must first obtain a medical clearance prior to initiating exercise due to the following risk factors or conditions:

_____

The activity will involve the following:

Static, Postural, Dynamic Movement Assessments, Manual Muscle Tests, Exercises

If your patient is taking medications that will affect his or her exercise capacity or heart-rate response to exercise, please indicate the manner of the effect (raises or lowers exercise capacity or heart-rate response):

Type of medication(s)_____

Effect(s) _____

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

_____

_____

Please identify any medications that could increase your patient's risk for problems while exercising:

_____

_____

Thank you.

Sincerely,

Andy Curtiss - BEXSc, CPT*D, CES, PES (NASM), SNC, CNLP

Max U LLC - 223 Trey Ct. Clarksville, TN 37043 (682) 559-8661

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

Signed_____Date_____Phone_____