



Physician's Clearance 8/03

Physician's Release and Guidelines for Participation in an Exercise Program

Dear Dr. _____,

Your patient, _____, wishes to start an exercise program. The activities that she/he will participate in include the following:

- Weight Training
- Cardiovascular Training

Please check the appropriate response below:

1. Exercise is approved with no restrictions
2. Exercise is approved with the following restriction(s):

3. Exercise is not approved at this time

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

Type of medication (s) _____

Effect(s) _____

Thank you for your willingness to support _____ in his/her pursuit of improved health.

If you would like to learn more about our athletic development and fitness programs, I would be glad to meet with you and review the structure and content of the program.

Sincerely,

Joel A. Lenker, CFT, LWMC
IAD Director
(717) 357-0164

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

Signed _____ Date _____