



# Doctor's Patient Participation Release Form

*Doctor's Medical Release Form for Physical Fitness Training*

## **Patient Information**

Patient's Full Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Apart. Suite, etc: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I, the undersigned healthcare provider, hereby confirm that I have examined the above-named patient and find them medically fit to participate in physical fitness training.

## **Health Assessment**

**Overall Health Status:**     Excellent     Good     Fair     Poor

**Known Medical Conditions** *(List any known medical conditions or concerns.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications:** *(List current medications and dosage.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Physical Fitness Recommendations:**

Based on my examination, I recommend the following guidelines for the patient's participation in physical fitness training:

**Types of Exercise:**     Aerobic exercises     Strength training     Flexibility exercises

**Intensity Level:**     Low     Moderate     High

**Frequency:** *(Specify the number of days per week.)* \_\_\_\_\_

**Duration:** *(Specify the length of each session.)* \_\_\_\_\_

**Restrictions or Limitations:** *(Specify any restrictions or limitations on specific exercises or activities.)*

1. Cardiovascular Activities: *Restrictions, if any.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Strength Training: *Restrictions, if any.*

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3. Flexibility Exercises: *Restrictions, if any.*

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**Emergency Contact Information**

Emergency Contact Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Emergency Contact Phone Number: \_\_\_\_\_

**Authorization:**

I hereby authorize and recommend the patient's participation in physical fitness training based on the guidelines provided above.

**Healthcare Provider's Information**

Doctor's Full Name: \_\_\_\_\_  
Medical License  
Number: \_\_\_\_\_  
Medical Practice/Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apart. Suite, etc: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number (if applicable): \_\_\_\_\_

Signature:

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Date: \_\_\_\_\_