



Medical Waiver

Dear Dr. _____,

Your patient, _____, wishes to begin a personalized exercise program. The program will consist of a combination of aerobics conditioning, resistive training, as well as stretching and mobility exercises. Please indicate and check the appropriate box for your patient:

No contraindications for participation in general exercise program

Participation in exercise program is recommended with the following restrictions or modifications:

I do not recommend participation in a general exercise program at this time

Please list any medications your patient is taking, the reason for taking them, and whether they have any effect on blood pressure, heart rate, or exercise response and what that response would be

If available from your patient's last visit or exam, please provide the following:

Resting Blood Pressure ____ / ____ / ____ mm Hg Resting Pulse ____ bpm

Total Cholesterol _____ mg/dl HDL's _____ mg/dl LDL's _____ mg/dl

Physician's Signature

Date (YYYY/MM/DD)

Address

Phone