northwest core balance a pilates studio

Physician Release Form

Client's Name: _____

Physician/Physical Therapist _____

Address _____ **Phone:** _____

City _____ **State** _____ **Zip** _____

Diagnosis: _____

I hereby give medical approval to the person named above to participate in a post-rehabilitation fitness program that may include cardiovascular, resistance training and functional conditioning for the body.

Please note any exercise recommendations or restrictions: _____

_____

_____

Please note any medications that may affect his/her response to exercise: _____

_____

_____

_____ _____

Signature: Physician/Physical Therapist **Date**

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