**UIC**

Wellness House for LIVING with CANCER
You'll feel better inside.

# PHYSICIAN MEDICAL RELEASE
## Exercise Program

### To Be Completed by Participant:

Date ____/____/____ Patient name ________________________________ Birthdate ____/____/____

I, ______________________________________ authorize my physician to release my personal health information to Wellness House for the purpose of participation in the Exercise Program.

Patient Signature ____________________________________________________________________

### To Be Completed by Physician:

**Wellness House Exercise Programs consist of:**

- Instructor-led aerobic, muscular strength/endurance, balance and flexibility training
- Voluntary Fitness Assessments

I approve of the aforementioned patient participating in Wellness House exercise programs. Please list specific restrictions or contraindications:

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Blood Pressure:
Blood pressure within ranges of systolic 90 to 140 and diastolic 60 to 90 are required to complete a voluntary Fitness Assessment. If participant is known to experience blood pressure out of this range, please indicate that it is acceptable for participant to complete an assessment when blood pressure is
within the following ranges: Systolic ____ to ____ and Diastolic ____ to ____. Blood pressure monitoring prior to regular exercise class is available at physician request.

**Print Physician's Name** ______________________________________________________________

**Physician's Signature** ________________________________________________________________

**Medical Office Name/Affiliation** _______________________________________________________

**Medical Office Phone Number** _________________________________________________________

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