

**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 _____

For questions regarding medical release, please call Anna Blazevic, Program Coordinator (630) 654-5355. Forward faxes to (630) 654-5345.