Medical Release Form

Date: _____
Dear Doctor: _____

Your patient _____ wishes to start a personalized training program. The activities will involve any combination of the following components of exercise: cardiovascular training, strength training with machines, resistance bands, body weight and/or free weights, aquatic exercise, and flexibility training.

If your patient is taking medications that will affect his or her heart-rate response to exercise, please indicate the type of medication and manner of the effect (raises, lowers or has no effect on heart- rate response):

Type of medication: _____
Effect: _____

Type of medication: _____
Effect: _____

If your patient is taking any other medications please list their type, function, and potential side effects that may affect their exercise program below:

_____
_____
_____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program: _____

_____
_____
_____

Thank you,
Temple University Campus Recreation

_____ has my approval to begin an exercise program with the recommendations or restrictions as stated above.

Doctor's Printed Name: _____

Doctor's Signature: _____ Date: _____
Phone:_____ Email:_____

If you have any questions please contact the Fitness Coordinator at 215-204-9697