



MEDICAL RELEASE FORM

Please return this form to Providence Wellness Center. Individuals joining are required to have this completed and, in our files, before they can begin.

Name: _____

Date: _____

Address: _____

Date of Birth: _____

I authorize my physician _____ to release information to Providence Wellness Center concerning any medical condition, which may affect my exercise capacity.

Signature: _____

Witness: _____

Are there any conditions that may affect this person's exercise capacity? Y_____ N_____

If yes, please explain:

_____ No restrictions on physical activity

_____ Restricted/contraindicated physical activity/exercise

If restricted/contraindicated physical activity/exercises are indicated, please list those exercises below:

Signature of Physician

Date

Thank you for this information. It will allow us to establish a sound and safe exercise program.