FIT FOR 2 PHYSICIAN RELEASE FORM

Patient's name: ____ Date of birth:_________________

Address:____

Phone numbers, home: _________________________________, cell:______________________________

Your patient, ______________________________ (noted above), wishes to participate in ProRehab's Fit For 2 pregnancy/post-partum exercise class hosted by ProRehab-PC 415 Crosslake Drive, Evansville, IN 47715, USA. This class is conducted by licensed physical therapists who are employed by ProRehab-PC.

Fit For 2 includes mild to moderate strenuous physical activity that includes, but is not limited to, muscular resistance and strengthening, endurance training, cardiovascular conditioning, and stretching.

My recommendations as this patient's physician include (please check the ONE appropriate statement):

_____ I am not aware of any current health conditions, diseases, or medications that limit this patient's full participation in the Fit For 2 exercise class.

_____ I believe that this patient can fully participate in the Fit For 2 exercise class, but urge caution due to (please specify):

____

____

_____ I believe this patient may participate in the Fit For 2 exercise class, but should not engage in the following activities: ____

____

_____ This patient should NOT participate at any level in the Fit For 2 exercise class.

_____________________________________ (MD signature) _________________ (date)

_____________________________________ (physician's printed name)

Physician's Work Address: ____

Physician's Work Phone Number: ___________________________

Fax:___________________