

Member Name (please print) \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

I give my physician permission to release to Christian Care Ministry any medical information or files deemed relevant to my participation in an exercise program.

I understand that my participation in the program requires a physician's approval before I can receive guidance for a progressive exercise routine. I agree to notify my physician and my coach any medical changes or symptoms that occur while participating in the program.

Note: Individual exercise programs are designed and monitored in keeping with any limitations noted by the physician, and take into consideration medical conditions and history, exercise history, fitness level, available resources/equipment, climate and goals.

Areas of exercise include:

- ✓ aerobic
- ✓ muscle strength and muscle power
- ✓ range of motion/flexibility
- ✓ skilled movement (for balance, coordination and agility)

Member Signature \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

☐ Patient should not engage in an exercise program at this time.

☐ Patient has my permission to engage in an exercise program without restriction, assuming the program to be appropriate for his/her level of fitness and health-related goals.

☐ Patient has my permission to engage in an exercise program with the following **precautions, restrictions, conditions or limitations** (please note any history of injury or orthopedic surgery):

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☐ See back of sheet

☐ See attached sheet(s)

Physician Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Physician Name \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_