PERSONAL TRAINING PROGRAM PHYSICIAN'S RELEASE

Date_____

Dear Doctor,
Your patient, (name)_____wishes to start a personalized training program through The Ohio State University Department of Recreational Sports. The activity will involve the following (type, frequency, duration, and intensity of activities- refer to guidelines on page 1-2 of this packet):

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

Type of medication:

Effect:

Please provide any recommendations or restrictions that are appropriate for your patient in this exercise program.

Thank you. Sincerely,
The Ohio State University Personal Training Program
RPAC
337 West 17th Ave.
Columbus, Ohio 43210
614-292-4105 Fax

(Patient's name)_____has my approval to begin an exercise program with the recommendations or restrictions stated above.

_____

Physician's Signature Date Physician's Phone Number