PHYSICIAN'S APPROVAL FOR PHYSICAL ACTIVITY

Client/Patient Name: _____ **D.O.B.**_____

Client/Patient Signature:_____ **Date:**_____

Physician's Name:_____ **Clinic**_____

Physician's Phone # _____ **Fax #**_____

Your patient desires to engage in a personal training program at **XO Fitness**, a personal training studio in De Pere, WI. The primary objective is the promotion of health and fitness through an individualized exercise program designed by a certified Personal Trainer.

The program may include fitness assessments and supervised exercise involving muscle, flexibility and aerobic conditioning. All programs are based on the general guidelines established by the American College of Sports Medicine. All Personal Trainers hold nationally recognized certifications in personal training and current CPR certifications.

❍ This patient is under my care and there are **no limitations** to his/her participation in an exercise program.

❍ This patient is under my care and **there are limitations** to his/her participation in an exercise program (describe below). Please note any medications that may affect the patient's heart rate response and/or ability to exercise safely.

_____
_____
_____
_____
_____
_____

❍ This patient is under my care and due to his/her limitations **cannot participate** in an exercise program.

Physician's Signature: _____ Date:_____

Please complete this form and fax to 866-892-4803. Thank you!

XO Fitness
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920-339-0630 • fax 866-892-4803 • www.xofitness.com