# Doctor's Consent to Exercise

Dear Doctor ________________________________

Your patient _______________________________________________ wishes to take part in an exercise programme and/or fitness assessment. The exercise programme may include progressive resistance training, flexibility exercises, and a cardiovascular programme, increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, and muscular strength and endurance.

After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advice in setting limitations to their program.
By completing this form, you are not assuming any responsibility for the exercise and assessment program.
Please identify below (Doctor's Recommendations) any recommendations or restrictions that should be applied to your patient's fitness program.

**Patient's Consent and Authorization**

I (patient) ________________________________ consent to and authorize the release and sharing (between my Doctor/GP and Trainer/Therapist) of health information concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken.

Authorization is not valid beyond one year from date of signature. Further disclosure, release or sharing of health information is prohibited without specific written consent of person to whom it pertains.

Patient's signature ____________________ Date ______________

Trainer/Therapist's signature ____________________ Date ______________

**Doctor's Recommendations**

(tick and comment as required)

☐ I am not aware of any contraindications toward participation in a fitness training program.

☐ I believe the applicant can participate, but urge caution because:
_________________________________________________________
_________________________________________________________
_________________________________________________________

☐ The applicant should not engage in the following activities:
__________________________________________________
__________________________________________________
__________________________________________________

☐ I recommend the applicant not participate in the above fitness program.

☐ I require further information before I can make recommendations.
__________________________________________________
__________________________________________________
__________________________________________________

Doctor's name ____________________________

Doctor's signature ____________________________ Date _______________

**Medical Practice Address and Contact number:**

After completion please return this form to the patient or sent to:

SDPT, Birchdene Westwood Avenue, Addlestone, Surrey. KT153QF.