HEALTH CARE PROVIDER'S CONSENT FORM

Client's request for Clearance to participate in a Fitness Assessment and Exercise Program

Dear Dr.____________________________________:

Your patient, _________________________________, has expressed interest in beginning a supervised exercise program with a certified personal fitness trainer, _________________.
This program may include a series of fitness assessments including any or all of the following procedures: a submaximal aerobic capacity test, a body fat estimate, flexibility test(s), and a battery of muscle strength and endurance measurements. The nature of both the exercise testing and programming will depend on your patient's (1) stated health history as indicated from a completed health risk appraisal form, (2) stated fitness goals, and (3) feedback from his/her health care providers. All programming is done in accordance with the guidelines of the American College of Sports Medicine and the stated trainer is CPR and First Aid certified.

By completing this Consent Form, you are not assuming any responsibility for the administration of the fitness tests and/or exercise program. If, however, you are aware of any reasons, medical or otherwise, which might impact or be impacted by participation in an exercise program or fitness testing, or are aware of any specific precautions and/or contraindications and/or guidelines that should be considered by the fitness trainer, please use the spaces below to provide sufficient detail.

If you have any questions regarding these matters, please call Ken Hughes, the Head Trainer at (615) 394-9194. Any other questions or concerns should be directed to this patient.

Please place your initials beside the appropriate statement(s) and complete those that apply.

________ I know of no reason(s) why my patient, _____________________________________
should not participate in any fitness tests or exercise programming.

_______ To the best of my knowledge, I believe my patient is able to participate in exercise testing and exercise programming with the following restrictions and/or recommendations:
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_______ I recommend that my patient does NOT participate in any exercise testing or programming until such time as I have consulted with him/her again.

_______________________________________ Date: _______________________
(Health Care Providers Signature)

_______________________________________ Phone Number:___________________
(Please print your name here)