

# OPTIMUM FITNESS & REHABILITATION CENTER

## Fitness Center Membership – Physician’s Consent

Dear \_\_\_\_\_,

Your patient is interested in becoming a participant in an exercise program at Optimum Fitness & Rehabilitation Center. The patient will be allowed to participate in an individualized and unmonitored exercise program. Please provide the information requested, and choose one of the following statements at the bottom of the page.

Patient Name: \_\_\_\_\_

Does the patient have any of the following conditions:

Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone/Joint disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide any information about the patient’s medical history which may affect their participation in a regular exercise program:

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE NOTE: Although our staff is CPR certified, we do not have a crash cart.**

I authorize my Doctor to release my medical records to Optimum Fitness & Rehabilitation Center regarding my gym membership.

**Patient Signature:** \_\_\_\_\_

There is no contraindication to participation in a self-monitored moderately vigorous exercise program.

This patient is not advised to participate in a self-monitored moderately vigorous exercise program.

**Physician signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please return this form to Optimum Fitness & Rehabilitation Center.  
Phone 239-303-1501 Fax 239-303-9297*