FULTON COUNTY

OFFICE OF AGING SENIOR MULTIPURPOSE FACILITY

MEDICAL RELEASE FORM

(REQUIRED FOR AQUATICS & FITNESS PROGRAMS)

PHYSICIAN SIGNATURE REQUIRED

****PLEASE READ AND COMPLETE CAREFULLY****

YOUR PATIENT _____ WISHES TO BEGIN SUPERVISED INDEPENDENT USE OF OUR FITNESS ROOM AND POOL. THIS MAY CONSIST OF GROUP TRAINING PROGRAMS AND WILL INVOLVE THE FOLLOWING FORMS OF EXERCISE:

1. CARDIOVASCULAR (AEROBIC) EXERCISE USING THE POOL, TREADMILLS AND/OR STATIONARY CYCLES AT A LOW TO MODERATE INTENSITY FOR THREE (3) TO FIVE (5) DAYS PER WEEK.

2. RESISTANCE TRAINING USING CIRCUIT WEIGHT TRAINING EQUIPMENT AND/OR LIGHT DUMB BELLS AT A LOW TO MODERATE INTENSITY FOR TWO (2) TO THREE (3) DAYS PER WEEK.

3. STRETCHING AT LOW TO MODERATE INTENSITY EVERY DAY.

*****IF YOUR PATIENT IS TAKING MEDICATION THAT WILL AFFECT HEART RATE RESPONSE TO EXERCISE, PLEASE INDICATE THE MANNER OF THE EFFECT (I.E. RAISES, LOWERS OR HAS NO EFFECT ON HEART RESPONSE).**

TYPE OF MEDICATION: _____

EFFECT: _____

CONTRAINDICATIONS: _____

PLEASE INDICATE THE PROGRAMS IN WHICH THE PATIENT MAY PARTICIPATE BASED ON THEIR CONDITION. CHECK ALL THAT APPLY:

1. **FLEXIBILITY EXERCISES** _____
2. **AEROBIC/ENDURANCE ACTIVITIES** _____
3. **RESISTANCE TRAINING** _____
4. **SWIMMING/WATER EXERCISES** _____

FOR PHYSICIAN ONLY

_____ HAS MY APPROVAL TO BEGIN EXERCISE WITH THE RECOMMENDATIONS OR RESTRICTIONS STATED ABOVE.

PHYSICIAN'S SIGNATURE FOR APPROVAL: _____ DATE: _____