

Total Human Performance LLC

Medical Release Form

Date: _____

Dear Doctor: _____ (print doctor name)

Your patient (your name) _____ wishes to start/continue a physical fitness exercise program.

The activity will involve the following:

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has not effect on heart-rate response):

Type of medication: _____

Effect: _____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

Thank you.

Sincerely,

Kevin R. Burgess, CSCS, ACE-CPT, ACE-CHC, Pn1
dba Total Human Performance LLC
34 Silverton Dr
Nashua, NH 03062
(603) 402-9196

Yes _____ (patient name) HAS my approval to begin an exercise program with the recommendations and restrictions stated above.

No _____ (patient name) DOES NOT HAVE my approval to begin an exercise program.

Signed: _____ Date: _____ Phone: _____

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