Dear Physician:

Your patient _____ _____ wishes to take part in a pilates program of exercise. This program will include progressive resistance training, flexibility exercises, and cardiovascular challenges.

Please advise in setting limitations to their program or let us know if a pilates exercise program is contra-indicated for your patient, at this time. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize _____ _____ to release to _____ _____, 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. Please inform Pilates Center of Winter Garden if protocol should change at 407-732-8288 or pilatescenterofwintergarden@gmail.com.

Member's signature	Date
Trainer's signature	

Physician's Recommendations

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

Physician's signature		Date
Physician's name (print)	Phone	Fax
Address	City	State & Zip