Dear Physician,

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

Please advise us to set limitations, conditions, or restrictions on your patient's program or let us know if a Pilates exercise program is contra-indicated for your patient at this time. Please identify any limitations, conditions, or restrictions for your patient's fitness program in the "Physician's Recommendations" section below.

Patient's Consent and Authorization

I consent to and authorize ____ to release to Pilates Center of Winter Garden, LLC, health information concerning my ability to participate in a Pilates exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Please immediately inform Pilates Center of Winter Garden at 407-732-8288 or pilatescenterofwintergarden@gmail.com of your physician's recommended fitness protocol changes.

Patient's signature: ___________________________________ Date: ___________

Physician's Recommendations:

☐ I am not aware of any contraindications toward participation in a Pilates program:

___ Private Sessions ___ Duet/Trio ___ Small Group Classes

☐ I believe the applicant can participate, but urge caution because:

____

____

☐ The applicant should not engage in the following activities/movements:

____

____

☐ I recommend the applicant **NOT** participate in a Pilates fitness program.

Physician's signature: _____________________________ Date: ________________

Physician's name (print): ___________________________ Phone: ______________