



**Medical Release Form
Virginia Tech Fitness - Personal Training Program**

Date: _____

Personal Trainer Name: _____

To Physician:

Your patient _____ wishes to start a personalized training program through the Virginia Tech Fitness - Personal Training Program. The activities involve the following:

Type of Activity:	Time/Duration/Intensity:
Cardiovascular	_____
Resistance Training	_____
Flexibility	_____
Other	_____

Additional Notes from Trainer:

Physician' Recommendations:

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

Please list any medications that your client is currently taking which would impact exercise training:

If your patient is taking medications that will affect their heart rate response to exercise, please indicate any effect (raises, lowers, has no effect on heart rate response):

_____ has my approval to begin an exercise program with the recommendations or restrictions stated above.

Physician's Signature _____

Date _____

Phone _____

(Please print your name here) _____

Thank you for taking the time to fill this out. Please fax to:

Steven Trotter
Fitness Coordinator
Department of Recreational Sports
Phone: (540) 231-1658
Fax: (540) 231-6273
satrotte@vt.edu