



Foothills
Park & Recreation District
PHYSICIAN CONSENT FORM
PERSONAL TRAINING

TO: _____
 Physician's Name (please print)

 Physician's Address

 City State Zip

 (_____) _____
 Telephone #

RETURN TO:	
Fitness Program Staff	
Foothills Park & Recreation District	
6612 S Ward St	
Littleton, CO 80127	
Telephone:	(303)409-2263
	(303)409-2264
Fax:	(303)409 2241

Your patient, _____, has asked to participate in an exercise program at Foothills Park & Recreation District that includes fitness assessments, strength training and aerobic activity. This is a physical training program designed to instruct proper techniques and methods for exercising, and to increase overall fitness levels. This program will involve:

1. Specific fitness tests to establish baseline measures of physical fitness.
2. Warm up, cool down, dynamic, and stretching exercises.
3. Balance with support as needed including one leg stands, fitball exercises, unstable surfaces & more.
4. Use of Cable cross, life fitness, and free weight training equipment, dumbbells, and/or therabands.
5. Shifting between standing, seated, and supine positions to perform exercises.

The activities and testing exercises are administered by certified personal training staff and proper emergency procedures are in place. Exercises are discussed and demonstrated by the training staff prior to participant's execution of the activity. Participants are informed that their participation is voluntary and are instructed to perform activities to the best of their abilities and without overexertion or endangerment to their well being.

Patient Health Release

My signature below indicates that I am authorizing my treating medical professional to release the requested information to the Foothills Park & Recreation District's Fitness Programs.

Patient Signature: _____ Date: _____

Printed Name: _____

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Please indicate below if this program seems appropriate for your patient or if you see any contraindications for his/her participation (please check the appropriate box below).

- I know of no contraindications to this patient in any of the above components of the program.
- I feel that this program would be appropriate for this patient with the following adaptations or restrictions:

- I feel that this program would not be appropriate for this patient for the following reason(s):

Physician's Signature: _____ **Date:** _____