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 Department
Foothills Park & Recreation District 6612 S Ward St
Littleton, CO 80127
Phone: (303)409-2263
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 a variety of strength, cardio, balance and other fitness equipment including cardio and circuit machines, free weights, Suspension Trainers, bands/tubing, dumbbells, medicine balls, ropes, etc.
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: _____
(Parent/Legal Guardian if under 18)

Printed Patient Name: _____ Patient Phone: _____

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:** _____