

Medical Release Form

Participant Name: _____ **Date:** _____

Dear Dr. _____,

Your patient, _____, wishes to participate in a running fitness program. The activities will involve running _____ times per week for a duration of about _____. There will also be light to moderate calisthenics involved. The program will last _____ weeks.

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

Also, if your patient is taking medications that will affect her heart rate response to exercise, please indicate the type of medication and the manner of its effect:

Medication: _____

Thank you.

Liz Lindsay

_____, has my approval to participate in this fitness
(patient's name)
program with the recommendations or restrictions as stated above.

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

Phone: _____

Deliver to: Liz Lindsay
Janes on the Run Women's Running Network
Greensboro Fitness Company
2505 A Carroll Street Greensboro, NC 27408
Phone: 336.402.3985 **Fax:** 336.217.8721
info@janesontherun.com www.janesontherun.com