Dakotah!
SPORT AND FITNESS

PHYSICIAN CONSENT FORM

Date _____

Dear Dr. _____ ,

Your patient _____, wishes to participate in an exercise program at Dakotah Sport and Fitness. If your patient is taking medication that will affect their heart rate response to exercise or if your patient is taking medication that will create an adverse effect during exercise, please indicate the manner of the effect (raises, lowers, or has no effect on heart rate response or other effects):

Type/Name of Medication: _____

Effect: _____

_____

Type/Name of Medication: _____

Effect: _____

_____

Report of Physician:

_____ I know of no reason why this applicant may not participate in exercise.
Suggestions:

_____

_____

_____ The applicant should not engage in the following activities:

_____

_____

_____ I recommend that the applicant NOT participate in physical activity at Dakotah Sport and Fitness.

_____ _____
Physician Signature Date

Please mail or fax the completed form to:
Mail:
2100 Trail of Dreams
Prior Lake, MN 55372

Fax #: 952-496-6880

Thank you,
Dakotah! Personal Training Staff
952-496-6874