



RESHAPE
DESIGNING THE NEW YOU

PHYSICIAN RELEASE FORM

Patient Name: _____
(Please Print)

Patient Phone #: _____

I, _____, wish to begin an exercise program at **RESHAPE**
Patient Signature
, **LLC**. Please list below any physical limitations or restrictions and any medications that might assist my instructors in designing an exercise program specific to my needs.

CURRENT MEDICATIONS:

_____ I RECOMMEND THAT THE PATIENT PARTICIPATE IN AN EXERCISE PROGRAM BUT URGE CAUTION DUE TO THE FOLLOWING LIMITATIONS and/or /RESTRICTIONS:

_____ I **DO NOT** RECOMMEND THAT THE PATIENT PARTICIPATE IN AN EXERCISE PROGRAM.

Except as stated above, I am not aware of any consideration, which under ordinary circumstances would interfere with this patient performing moderate level physical activity. He/she may exercise at his/her own risk.

_____ M.D.
Physician Name (please print)

Physician Signature

Date

Office Telephone Number

Thank you for your cooperation and your commitment to your patient's overall wellness.

Sincerely, **RESHAPE, LLC**