Physician Medical Release Form

(To be completed by your physician)

Date: _____/_____/_____

Doctor's Name: _____

Your patient, _____, DOB _____/_____/_____, wishes to participate in the Rock Steady Boxing (non-contact) exercise program for people living with Parkinson's disease. Our goal is to help your patient have a better quality of life through fitness and socialization. The activities may involve cardiovascular training, flexibility instruction, resistance training and core strengthening techniques. Safety and modifications for level of fitness and disease progression are always considered.

PHYSICIAN'S RECOMMENDATION

☐ I am not aware of any restrictions to participate in this exercise program.

☐ I believe the patient can participate but would urge caution (explain): _____

_____

☐ Patient should not engage in the following activities: _____

_____

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers heart rate response during exercise):

Type of medication _____ Effect _____
Type of medication _____ Effect _____
Type of medication _____ Effect _____

(Patient's name) _____ has my approval to begin the Rock Steady Boxing program with the recommendations or restrictions stated above.

Physician's printed name: _____ Phone: _____

Physician's Signature: _____

Return to: Lisa Foer
1787 South Meadow Drive
Mechanicsburg, Pa 17055
Phone: 717-580-2635
Email: Harrisburg@rsbaffiliate.com