200 SE 37th ST, Suite 100
Grimes, Iowa 50111
515.331.7714
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Physician Medical Release Form

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Date: ___/___/______

Doctor's Name: ____

Your patient, ____, DOB ___/___/______, wishes to participate in the Ignit Sports and Fitness Neurological Disorder Program (NON-CONTACT) exercise program. The activity will involve cardiovascular training (jumping rope, running, punching boxing pads and bags), flexibility instruction (stretching, getting up and down on the floor), resistance training, and core strengthening techniques. Participants can attend up to five classes per week that are ninety minutes in duration. Participants can reach up to 90 percent of their maximum heart rate during the classes.

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 (please explain).

____

____

{ } Patient should not engage in the following list of 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, or has no effect on their heart rate during physical exercise):

____

____

Specify the type of Neurological disorder patient is diagnosed with:

____

Type of Medication: ________________________ Effect of Medication: ____

Type of Medication: ________________________ Effect of Medication: ____

Type of Medication: ________________________ Effect of Medication: ____

PHYSICIAN COMPLETES BELOW

____________________________________ (patients name) has my approval to begin the Ignit Sports and Fitness Neurological Disorder Program with the recommendations or restrictions stated above.

Printed Name ____ **Phone** __________________________________

Signature ____