

**Butler University
Department of Recreation
Personal Training
Medical Release Form**

Date / /

Dear Doctor:

Your patient, _____, wishes to start a personalized training program.

If your patient is taking medications that will affect their heart rate response to exercise or should limit certain types of movement, please indicate the manner of the effect (raises, lowers, or has no effect on the heart-rate response) and movement limitations:

Type of medication _____
Effect _____

Please identify any movement or general recommendations or restrictions that are appropriate for your patient regarding exercise:

**Thank you.
Sincerely,**

Chera Justice
Fitness Coordinator
Department of Recreation
Division of Student Affairs
Butler University
530 W. 49th St.
Indianapolis, IN 46208-3485
(P) 317.940.6121 (F) 317.940.6153

_____ has my approval to begin an exercise program with the recommendations or restrictions stated above.

Signed _____ Date / / Phone () -