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 ( ) -