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Physician's Form

Patient's Name: _____ DOB: _____ Phone: _____

Address: _____City:_____

List of all diagnoses:

1) _____

2) _____

3) _____

4) _____

5) _____

Weight: _____

Is there a DNR order? [ ] YES [ ] NO

Does Agency have a legal copy? [ ] YES [ ] NO

Medications: _____ _____

_____ _____

_____ _____

Allergies to Food and/or Medications:_____

_____ _____

Name of Person Participating in Exercise

The person named above is fit to participate in group exercises? [ ] YES [ ] NO

Please list any exercise and/or movement limitations and/or restrictions:_____

_____

_____

Current Activity Level: _____

Physician's Name: _____ Phone: _____

Address:_____

_____ _____

Signature of Physician Date