

Physician Release

Prenatal and Postpartum Fitness

This completed form or a prescription for prenatal/postpartum fitness can be brought to the first fitness class you attend.

Patient's Name: _____

Your patient wishes to start a prenatal fitness program tailored to healthy pregnant women. The program includes:

- Prenatal fitness classes, such as strength training, cardio fitness, yoga, and stretching
- Postpartum fitness classes, such as strength training, cardio fitness, yoga, and stretching

Please evaluate your patient and inform her of any restrictions you may recommend. Your initial approval will be in effect for the duration of your patient's pregnancy. If health changes occur, please advise your patient that a re-evaluation is needed. Please indicate below your approval of your patient's participation in the prenatal exercise class:

☐ My patient may participate without any restrictions in prenatal fitness classes

☐ My patient may participate without any restrictions in postpartum fitness classes

☐ With the following restrictions, my patient may proceed in prenatal or postpartum fitness classes: _____

If your patient is taking medications that will affect her heart rate response to exercise, please indicate the medication and the manner or the effect (raises, lowers, or has no effect) on the heart rate response.

Medication: _____

Effect: _____

Physicians Signature

Date

Physician's Printed Name

Office Phone Number