

# MEDICAL RELEASE FORM

Participants Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Program Name: Personal Training

## TO BE COMPLETED BY THE PHYSICIAN

I give \_\_\_\_\_ permission to participate in the personal training

Exercise program which is being offered by Renaissance Fitness.

\_\_\_\_\_ I know of no reason why the applicant may not participate

\_\_\_\_\_ I believe the applicant can participate, but I urge caution because

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\_\_\_\_\_ The applicant should not engage in the following activities

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\_\_\_\_\_ I recommend that the applicant NOT participate in the exercise program

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Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Renaissance Fitness (401) 301-5122 Fax (401) 846-8858