The Prescription Gym
108 Park Avenue, Athens GA 30601
Phone: (706) 546-9799 Fax: (706) 546-9044

Physician's Consent Form

Date: _____

Patient Name: _____ DOB (mm/dd/yy): _____/_____/_____

Patient Telephone Number:_____

Physician's Name: _____

Physical Health Status: (Please list absolute value.)

_____ Height

_____ Body Weight

_____ Blood Pressure

_____ Resting Heart Rate

_____ Fasting Blood Glucose

_____ Total Cholesterol

_____ HDL _____ LDL

***Physician's Statement:**

( ) The above named individual may participate, **without restriction**, in **all** activities offered at The Prescription Gym.

( ) The above named individual may participate, **with restriction**, in **limited** activities offered at The Prescription Gym. (An Exercise Specialist will design a program for the individual based on the stated restrictions.)

Restrictions: _____

_____

( ) The above named individual **may not participate** in activities and programs offered at The Prescription Gym.

Justification: _____

***This consent form is valid for: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 1 year**

Physician's Signature: _____

Phone Number: _____ Fax Number: _____

*required information