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 yoga, cardio fitness and water aerobics
- Postpartum fitness, such as yoga, cardio fitness and water aerobics

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 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 fitness or postpartum fitness classes: ____

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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: ____

____ ____________________

Physician's Signature Date

____ ____________________

Physician's Printed Name Office Phone Number