



Children's Workout Class

Physician Release Form

Clients Name: _____ Date: _____

Address: _____ City: _____

Zip: _____

Client DOB: __/__/__

Physician Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Telephone Number _____ Ext. _____

The form serves as a medical release for _____. I have assessed their physical condition and have determined that they are cleared for physical activity. Any limitation or restrictions to physical activity are listed below or can be found on an attachment, which must accompany this document.

Restrictions: _____

limitations: _____

Additional Comments regarding mental health (if none, write NONE) _____

Physician Signature _____ Date _____



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