

Medical Release Form

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Date: ____/____/____

Doctor's Name: _____

Your patient, _____, DOB ____/____/____ wishes to participate in the Rock Steady Boxing (NON-CONTACT) exercise program for people with Parkinson's disease.

Our goal is to help your patient have a better quality of life through fitness and socialization. The activities may involve:

1. Cardiovascular training (jumping rope, walking/running, punching heavy bags)
2. Flexibility and mobility instruction (stretching, getting up and down on the floor),
3. Resistance training and core strengthening exercises (using bands, dumbbells and small equipment)
4. Balance exercises (standing, sitting and dynamic)

Safety and modifications for various levels of fitness and disease progression are considered and tailored into the different groups as clients will undergo a basic assessment prior to participating.

PHYSICIAN'S RECOMMENDATION

- I am not aware of any restrictions to participate in this exercise program.
- I believe the patient can participate but would urge caution (*please explain*): _____

Patient should not engage in the following activities: _____

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers or has no effect on heart rate response during exercise):

Type of medication _____	Effect _____
Type of medication _____	Effect _____
Type of medication _____	Effect _____

PHYSICIAN to COMPLETE:

_____ (patient's name) has my approval to begin the Rock Steady Boxing exercise program with the recommendations or restrictions stated above.

Printed name _____

Phone _____

Signature _____

Please return a copy to: info@breathemoverelax.com.au