TriHealth
Fitness & Health Pavilion

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www.TriHealthPavilion.com

MEDICAL CONSENT FORM

Patient Name (print) _____ Patient Name (signature) _____

Date of Birth _____

I authorize my healthcare provider to release any health related information that would be relevant to my exercise program at the TriHealth Fitness & Health Pavilion.

The above individual would like to participate in a fitness consultation and personal fitness program at the TriHealth Fitness & Health Pavilion (the "Pavilion"). Please review the following information regarding the equipment and facilities available at the Pavilion and the fitness consultation to be offered to the patient. Please indicate your approval and recommendations regarding the patients use of the equipment and facilities and participation in a fitness consultation or any other personal fitness programs at the Pavilion.

Cardiovascular Equipment Includes But Not Limited To:
Treadmills, recumbent bikes, upper body ergometers, steppers, rowers, ellipticals, NuSteps, and arc trainers.

Strength Training Equipment Includes But Not Limited To:
Free weights, resistance machines, and aquatic resistance training.

Other Facilities Available:
Warm water therapy pool, lap pool, whirlpool, sauna, steam room, walking/jogging track, and group exercise classes.

General Fitness Consultation
The Pavilion's fitness consultation will include a series of non-diagnostic tests which will include: resting heart rate, resting blood pressure, height, weight, flexibility, body composition, muscular strength, as well as goal setting and wellness coaching.

Based on fitness consultation results, health history information provided by the client, and your approval and recommendations, a personal fitness program will be developed for the patient.

_____ This patient may participate without restriction in a fitness consultation and personal fitness program at the Pavilion.

_____ This individual may participate in a fitness consultation and personal fitness program at the Pavilion with the following medical recommendation:

_____

_____

_____ I would like to receive a copy of this patient's fitness consultation results. (Please include address or business card)

_____
Healthcare Provider's Address Telephone

Is there a MAXIMUM HEART RATE this patient should not exceed during aerobic exercise?

☐ Yes ☐ No If YES, please specify: _____ beats per minute

Are you aware of any medication this patient is taking regularly that would affect his/her response to exercise? If so, please describe.

_____

_____ _____
Healthcare Provider's Name (print) Healthcare Provider's Signature Date

<u>This section is to be completed if the patient's healthcare provider has given exercise restrictions</u>

I hereby acknowledge that I have consulted with the following individual(s) and understand the exercise recommendation my healthcare provider has given me:

☐ I have discussed the exercise recommendation with my healthcare provider

☐ I have discussed the exercise recommendation with the exercise specialist at the TriHealth Fitness and Health Pavilion

I understand the recommended levels of exercise I am to do and that there is the potential of serious health consequences if I exceed the recommended levels of exercise. I will follow-up with my healthcare provider directly to answer any questions I may have about the exercise recommendation given by my healthcare provider.

Patient Name: _____

Patient Signature: _____ Date: _____