Physician Medical Release Form

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Union City
Community & Recreation Services
www.unioncity.org

Date: _____/_____/_____

Doctor's Name:_____

Your patient, _____, DOB _____/_____/_____wishes to participate in the ***PARKINSON'S EXERCISE PROGRAM*** at the Mark Green Sports Center. This program consists of three different exercise classes designed for people diagnosed with Parkinson's Disease. These three classes are: *Rock Steady Boxing, PWR! Moves, and Dance for Parkinson's*. These activities will involve cardiovascular training (aerobic exercise movements, dancing, punching heavy bags and mitts, and jumping rope), flexibility instruction (stretching, getting up and down from the floor), resistance training and core strengthening techniques. Participants can attend up to four classes per week that are anywhere from sixty to seventy-five minutes in duration.

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 COMPLETES

_____ **(patient's name) has my approval to begin the Parkinson's Exercise Program at the Mark Green Sports Center with the recommendations or restrictions stated above.**

Printed name _____ **Phone** _____

Signature _____

RETURN TO
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(510) 489-8620