Healthy Driven
Edward-Elmhurst
HEALTH & FITNESS

Medical Fitness Program

Physician Consent Form

Edward Elmhurst Health & Fitness
On the Hospital Campus: 775 Brom Drive Naperville, IL 60540
At Seven Bridges: 6600 Route 53 Woodridge, IL 60517

FAX: (630)646-5955
EMAIL: medicalfitness@eehealth.org

____________________________________ would like to join the Medical Fitness Program at Edward-Elmhurst Health & Fitness (EEHF). Please review the following information about the exercise prescription and fitness consultation that the patient will be participating in. ***Form must be completed in its entirety and signed by referring Physician****

Exercise Prescription

The exercise prescription will consist of guidelines for mode, frequency, intensity, duration, and progression of both aerobic and strength training exercise. These guidelines will follow the recommendations of the American College of Sports Medicine.

Fitness Assessment

Following the American College of Sports Medicine protocols, the member may participate in a variety of non-diagnostic measurements of resting and exercise heart rate and blood pressure, weight, height, body composition, circumference measurements, submaximal cardiovascular assessments, posture assessment, muscle strength, muscular endurance, and flexibility.

Strength Training Orientations

The member may participate in strength training on various selectorized strength training machines, and/or free weight strength training exercise.

Program Orientation

The member may participate in aerobic and/or strength training programs that occur on stationary aerobic equipment, walking/jogging track, basketball/volleyball court, free weight room, aerobic studio, warm water therapy pool or lap pool.

As the personal physician of ____________________________________, I recommend the following: (check appropriate box)

__________ NO RESTRICTIONS: This individual may participate in the fitness consultation and any exercise program in the Edward-Elmhurst Health & Fitness without any restrictions in assessment or exercise prescription.

__________ RESTRICTIONS: This individual may participate in a fitness consultation and any exercise program in the Edward-Elmhurst Health & Fitness with the following restrictions:

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Patient DOB____________ Patient E-mail___________________________ Patient Preferred Contact Number________________

______________________________ **PHYSICIAN SIGNATURE**

______________________________ **PHYSICIAN NAME (PLEASE PRINT)**

______________ **DATE**

Provider Affiliation (ex. EEH, Duly, Northwestern, etc.) ____