Physician Verification and Medical Release Form

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Date: _____/_____/_____

Your patient, _____, DOB _____/_____/_____wishes to participate in a cardio Boxing (NON-CONTACT) exercise program. This program is designed specifically for people who have officially been diagnosed with Parkinson's disease; it is not intended for people with other neurological disorders. The activity will involve cardiovascular training (jumping rope, running, punching heavy bags), flexibility instruction (stretching, getting up and down on the floor), resistance training and core strengthening techniques. Participants can attend up to five classes per week that are ninety minutes in duration. Participants can reach up to 90 percent of their maximum heart rate.

PHYSICIAN'S VERIFICATION OF DIAGNOSIS

☐ I verify that the patient has been officially diagnosed with Parkinson's disease.
_____date of diagnosis

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 Rock Steady Boxing exercise program with the recommendations or restrictions stated above.**

Printed name _____ **Address** _____

Signature _____ **Phone** _____

Please return this to: Wolfpack Boxing Club | 1000 Gregg Street | Carnegie, PA 15106
info@wolfpackboxing.com | 412.335.2419