Medical Waiver

Date: _____

Dear Doctor, _____ wishes to participate in a Fitness Program at Naval Station Everett. My fitness prescription, with your consent will include the following activities:

	Cardiovascular	Resistance
Frequency:	4-6 times per week	2-3 times per week
Intensity:	60-85% of Max HR	Light to Moderate Weights
Type:	Variety of Aerobics/Cardio.	Variety of Routines
Time:	30-60 min/day as tolerated	30-45 min. per day

If your patient is taking any medications that will affect his/her heart rate response to exercise, please indicate the manner of the effect (raises, lowers, has no effect on heart rate response).

Type of Medication: _____

Effect/Response: _____

Please identify below any recommendation or restrictions that are appropriate for your patient in the above described fitness program:

*Heart Rate Zone*_____

	Cardiovascular	Resistance
Frequency:		
Intensity:		
Type:		
Time:		

Other Limitations:

_____

_____

_____

_____

Thank you for your time in assisting us at Naval Station Everett (MWR) Fitness to get our client on the road to health. If any other information is needed please contact the Fitness Manager at 425-304-3931.

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My Patient _____ has my approval to exercise in the above program with the recommendations, modifications, or restrictions as stated below:

**Physician's Directions*:

*Physician's Signature _____ *Date _____

Physician's Name Printed _____

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Patron's Name _____ Phone _____