

Rejuvenate Massage Therapy & Pilates Studio, LLC

**Physician Authorization to Participate Form**

Please take this form to your physician to be completed.

All clients planning to participate in our programs must complete a Health History Questionnaire. Only those clients indicating a “potential risk” on the Questionnaire are required to obtain physician approval prior to participation.

Patient Name \_\_\_\_\_

I. This individual has no known contraindications to participate in all fitness programs. Individual may participate in ALL programs.

Physician’s Signature \_\_\_\_\_ Date \_\_\_\_\_

II. This individual has some limitations, which will restrict full participation in all programs. Individual may participate with the following limitations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician’s Signature \_\_\_\_\_ Date \_\_\_\_\_

III. This individual currently requires a clinically supervised program and will require further medical clearance to participate.

Physician’s Signature \_\_\_\_\_ Date \_\_\_\_\_

If you have any questions or concerns about your patient in regards to these programs, please contact:

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