



Doctor's Medical Release Form

To be completed by your primary care provider

Date: _____

Doctor's Name: _____

Your patient, _____, DOB ____/____/____ wishes to participate in the Counterpunch Parkinson's (NON-CONTACT) exercise program. The activity will involve cardiovascular training (depending on ability - jumping rope, running, punching heavy bags), flexibility instruction (stretching, getting up and down on the floor), resistance training, postural correction, and core strengthening techniques. Participants will attend group exercise classes that are 60 minutes in duration. Participants can reach up to 90 percent of their maximum heart rate.

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*):

- The 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: _____
Type of medication: _____	Effect: _____

PHYSICIAN COMPLETES

_____ (patient's name) has my approval to begin the Counterpunch Parkinson's exercise program with the recommendations or restrictions stated above.

Printed name _____ Phone _____

Signature _____

Please return to: