WCTC Fitness Center
800 Main Street; room S-107
Pewaukee, WI 53072
262.691.5549

Personal Training Physician Letter
High Risk

RE: DOB:

Date:

Dear Primary Care Provider,

Your patient, , is planning to begin a supervised exercise program at WCTC's Fitness Center. All exercise programs are developed based on the individual's health history, current level of fitness, and desired goals. Our Fitness Specialist holds a Master's in Exercise Physiology and is a Certified Personal Trainer from the Aerobics and Fitness Association of America, as well as, CPR/AED and First Aid from the American Heart Association.

We value your input regarding this client's exercise prescription. At this time we are requesting the release of information that you feel would be beneficial to us in developing a safe and effective exercise program. If you know of any medical reasons that would contraindicate or limit this individual's ability to participate, please indicate your concerns. Enclosed you will find a HIPAA and state privacy law compliant authorization permitting you to disclose this client's health information. Please do not send any copies of medical records with your response. If you have questions, please contact Kristi Farmer at 262.691.5549 or kfinco@wctc.edu.

To be completed by primary care provider:

1. Due to health risks identified on this individual's health history form it is recommend that a physical exam be conducted before participation.

   ☐ A physical exam for this individual was conducted on: ___/___/_____

   ☐ I do not think it is necessary for this individual to complete a physical exam before beginning an exercise program.

   _____
   Physician's signature indicating exam is not needed.

2. Please Select One:

   ☐ I know of no reason why this individual may not participate in an exercise program and/or fitness testing.

   ☐ This individual may participate in an exercise program and fitness testing with the following precautions/limitations:

   _____

   _____

   _____

   ☐ I recommend that this individual not participate in an exercise program or fitness testing at this time.

Physician's signature_____Date_____

Physician's Name _____ Phone _____

Please return completed form by fax 262.691.5568 or
by mail WCTC Fitness Center 800 Main Street, Pewaukee, WI 53072.

WAUKESHA COUNTY TECHNICAL COLLEGE