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Corporate  
Wellcoaching

Fitness Training &  
Consulting Services

## PHYSICIAN RELEASE

**Patient's Name:**

I hereby give medical approval to the person named above to participate in various physical activity and exercise programs that may include fitness assessment, progressive exercise (e.g. aerobic, anaerobic, resistance training, and balance training) for conditioning the body. I further certify that there appears to be no reason why s/he should not actively participate in any fitness assessment or progressive training exercise program **except where noted below.**

**Note to Physician:** If \_\_\_\_\_ is taking any form of medication which might affect her/his response to exercise (i.e. heart rate, blood pressure, etc.), please indicate the possible effects that s/he might experience.

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**List any recommendations or restrictions you may have for this patient:**

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**Please provide the readings below (if available):**

<b>Total Cholesterol:</b>	<b>HDL:</b>
<b>Blood Pressure:</b>	<b>LDL:</b>
<b>Blood Glucose:</b>	<b>Other:</b>

**Please list any additional medication that is currently being taken by this patient:**

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**Physician's Signature:**

**Date:**

\* Ron Jones (8-7-04)

**Please mail completed form to above address or \*FAX \*(Call prior to FAX).  
E-mail questions to ron@ronjones.org or phone/FAX 770.513.9041.**