

## *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
<b>Frequency:</b> 4-6 times per week	2-3 times per week
<b>Intensity:</b> 60-85% of Max HR	Light to Moderate Weights
<b>Type:</b> Variety of Aerobics/Cardio.	Variety of Routines
<b>Time:</b> 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
<b>Frequency:</b>	
<b>Intensity:</b>	
<b>Type:</b>	
<b>Time:</b>	

*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 me at the following:

*Yours in Fitness,*

**Julia Krassin** Phone 425-304-3922  
**Fitness Specialist – Naval Station Everett**

**Fitness Specialists Staff:**  
**Dave Wald** Phone 425-304-3922

Naval Station Everet  
2000 W. Marine View Drive Bldg. 1950  
Everett, WA 98207-1700 Fax 425-304-3069

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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 \_\_\_\_\_

\*\*\*\*\*

Patrons Name \_\_\_\_\_ Phone \_\_\_\_\_