Home Help Plus

Feel Safe at Home

Medical Release Form for Personal Training

With over a decade of expertise in geriatric care, Home Help Plus LLC specializes in enhancing elderly independence through personalized balance training and functional exercises. Prioritizing health and safety, our programs are designed in collaboration with healthcare professionals to meet each client's unique needs. We are committed to providing attentive, specialized care that supports and respects the health journey of every participant.

Part 1: Patient Information

Full Name: _____

Date of Birth: ____ / ____ / _____

Address: _____

Phone Number: _____

Emergency Contact: _____

Relationship to Emergency Contact: _____

Emergency Contact Phone Number: _____

Part 2: Doctors Information

Doctor's Name: _____

Doctor's Contact Information:

Office number:_____

Address: _____

Email: _____

Part 3: Specific Medical Contraindications and Recommendations

1. Does the client have a history of heart disease? Y___ or N ____

If yes please list any contraindications or recommendations for a workout routine, such as max HR

_____

_____

2. Has the client had any orthopedic surgeries? Y___ or N ___

If yes please list, and please provide any contraindications or recommendations our personal trainers should be aware of such as THP:

_____

_____

3. Does the Client have any metabolic conditions such as type 1 or type 2 diabetes? Y ___ or N ___

If yes please list, and please provide any contraindications or recommendations our personal trainers should be aware.

_____

_____

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4. Does the Client have a history of COPD?: Y___ or N ___

If yes please provide any contraindications or recommendations our personal trainers should be aware of such as safe SPO2 levels during a session.

_____

_____

5. Does the client have osteoporosis? Y___ or N ___

If yes please list, and please provide any contraindications or recommendations our personal trainers should be aware of:

_____

_____

6. Does the client have any diagnosis related to neurological issues such as: MS, parkinson, history of stroke etc.? Y__ or N __

If yes please list, and please provide any contraindications or recommendations our personal trainers should be aware of:

_____

_____

7. Are there any specific medications the client should take prior to engaging in a personal training session:

   Y ___ or N ___

If yes please list, please mention if a training session should be canceled or rescheduled if a medication was missed.

_____

_____

8. Please use space below to list any other relevant medical history or precautions to consider for your patient.

_____

_____

_____

_____

_____

_____

9. Specific Exercise Recommendations or Restrictions not mentioned above:

_____

_____

_____

_____

_____

_____

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Part 4: Doctor's Acknowledgment

I acknowledge that I have reviewed the patient's current medical status and the recommended personal training program. I give my medical clearance for the patient to engage in the personal training program, considering the limitations and recommendations noted above.

Signature of Doctor: _____

Date: ____ / ____ / _____

Part 5: Consent of Patient

I, the undersigned patient, hereby give my consent to participate in the personal training program provided by Home Help Plus LLC. This program aims to improve my independence through balance training and functional exercises. I acknowledge that I have been informed of the nature of the exercises and the potential risks involved.

Patient Name: _____

Signature of Patient (or Legal Guardian): _____

Date: ____ / ____ / _____