MEDICAL RELEASE FORM

Participants Name: _____ Date of Birth _____ Sex ____

Address: _____ Phone: _____ Cell: _____ Email: ____

City: _____ State: _____ Zip: _____

Program Name: __Personal Training ___

TO BE COMPLETED BY THE PHYSICIAN

I give _____ permission to participate in the personal training program offered by Cybertrain.

_____ I know of no reason why the applicant may not participate

_____ I believe the applicant can participate, but I urge caution because

_____
_____
_____

_____ The applicant should not engage in the following activities

_____
_____
_____

_____ I recommend that the applicant NOT participate in the exercise program

_____
_____
_____

Physician's Signature: _____ Date: _____

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