Kim Cremin, MS
Exercise Physiologist, Pilates Instructor, Personal Trainer
304 Main Ave. South Hampton, NH 03827
C: (603) 303-4061 E: kacremin1@gmail.com FAX: 603-887-8811 (ATT: CHESTER REC)

Patient Name: _____ Patient DOB:_____

Provider Name: _____ Provider Address:_____

Provider Phone:_____ Provider FAX:_____

I give permission to my health care provider/physician to provide medical information to Kim Cremin, MS, regarding my participation in a health and fitness program. I understand that this information will be kept confidential to the extent allowed by the law and only those directly involved in the program will have access to this information

Patient Signature: _____ DOB:_____ Date: _____

Physician/Health Care Provider Consent to participate in a health and fitness program:
Your patient has agreed to participate in a fitness program. This letter is to notify you of their planned participation and to ask you to let us know if there is any reason why you might object to their involvement.

The core elements of the program are:

- Attendance of a fitness class, two times per week. Classes include balance and strength training exercises on and off a chair with body weight and resistance equipment (bands, balls, circles, dumbbells up to 8lbs). Emphasis is placed on good form, improving activity of daily living skills and working around any physical limitations/contraindications of each participant.
- Building social support for new behaviors through peer support.
- Monitoring of changes in physical activity levels for the duration of the client's participation.

Please indicate below if there are any medical concerns related to your patient's participation in this program. Also, if you require more information, please feel free to contact Kim Cremin.

Yes	No	
□	□	Cardiac Arrhythmias or history of MI
□	□	Cerebral Vascular Accident or Transient Ischemic Attack
□	□	Uncontrolled High Blood Pressure
□	□	Severe Osteoporosis
□	□	Severe Arthritis of the ankle, knee, hip or back
□	□	Neurological disorders that effect cognitive and/or muscular function
□	□	Diabetes
□	□	Peripheral Vascular Disease or Peripheral Neuropathy
□	□	Medications that may affect exercise performance or heart rate _____
		_____
□	□	Other _____

Please list any exercise guidelines, limitations or other information you feel is important for your patient's well-being:
_____
_____

Please check one of the following:
□ I see no contraindications for the patient to participate in a health and fitness program
□ I do not believe that it is safe for the patient to participate in a health and fitness program

_____ _____ _____ _____
Health Care Provider Printed Name Date Health Care Provider Signature Date

Please mail this information to Kim Cremin, 304 Main Avenue South Hampton, NH 03827 OR FAX: 603-887-8811 (ATT: CHESTER REC)