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**Physician's Release Form**

Physician's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Physician's Phone: \_\_\_\_\_ Location (city): \_\_\_\_\_  
Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Physician's comment regarding patient's medical condition(s), allergies, medications, etc.:

Physician's signature for release of patient to exercise under prescribed conditions:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_