**RECORD REQUEST**

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

In order to comply with all patient confidentiality guidelines, we are requesting that you complete this release form, which will allow us to communicate with your physician, therapist, coach or other provider, if we have any concerns related to your medical history. If you do not currently have a physician, please list your most recent physician’s information and date of last visit.

We are requesting that health care provider consent be issued to:

GVSU Recreation & Wellness Center

Attention: John Offerman

D135 Recreation Center

Allendale, Michigan 49401-9403

Provider consent is being requested from (Doctor, therapist, coach or other provider):

Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name: I, , am aware that the Grand Valley State University Fitness & Wellness Center is communicating with my health care provider and hereby give permission to do so.

Client Information:

Name:

(Please Print)

Signature:

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:

Address:

Reason for requesting records: Participation in GVSU’s Ufit program

**HEALTH CARE PROVIDER CONSENT FORM**

**NAME**: \_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

The above-named patient wishes to participate in a fitness appraisal and personal exercise

program with Grand Valley State University, Fitness & Wellness which includes the following physical activities:

* Participation in a fitness assessment
* Body composition assessment using the skinfold caliper technique
* Muscular strength and endurance of upper and lower body
* 5-10+ minute warm-up/cool-down (light exercise)
* 20+ minutes of moderate-vigorous aerobic activity (stairstepper, treadmill, bicycle, rowing, plyometrics, etc).
* 10-30+ minutes weight/resistance training
* 5-10+ minutes stretching exercises

**HEALTH CARE PROVIDER’S (HCP) STATEMENT**

The above-named individual has no medical restrictions or contraindications to participation in any of the activities stated above.

The above-named individual has the following limitations to participating in the fitness appraisal and/or personal exercise program. (Professionally degreed faculty or staff will supervise the design of a program for the employee based upon these limitations).

**LIMITATIONS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above-named individual should not participate in any of the above stated activities with GVSU Fitness & Wellness, based on the following limitations.

**LIMITATIONS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HCP SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Note:*** *For more information, please contact John Offerman, Assistant Director Campus Recreation, Rec Center D135, Allendale, MI 49401-9403, or phone number 616-331-2157, or fax 616-331-3960.*

CLIENT STATEMENT (**to be completed by client once form is returned from health care provider**):

I have read the above Health Care Provider’s Statement stating that I may participate in all of the activities with Grand Valley State University Fitness & Wellness.

I have read the above Health Care Provider’s Statement regarding my limitations, and I agree to adhere to these limitations.

**CLIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_