Healthy Transitions Health Coaching, LLC Medical Release Form

Date: _____

To whom it may concern:

Your client/patient, _____, wishes to start a personalized wellness program with Sarah Torok-Gerard, owner and operator of **Healthy Transitions Health Coaching, LLC**. The activity may involve the following: (type, frequency, duration, and intensity of activities- TBD during initial consultation)

If your client/patient is taking medications that will affect his or her 1) exercise capacity or heart-rate response to exercise, 2) ability to metabolize certain foods, or 3) ability to otherwise maintain a wellness program, please indicate the manner of the effect (raises, lowers, or has no effect on exercise capacity or heart-rate response, poses drug interactions with certain foods, etc.):

Type of medication(s)

_____
_____

Effect(s)

_____
_____
_____

Please identify any recommendations or restrictions that are appropriate for your client/patient in this wellness program:

_____
_____
_____
_____
_____
_____

In good health,

Sarah E. Torok-Gerard, Ph.D., CHC
NCCA Certified Health Coach, **American Council on Exercise**
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_____ has my approval to begin a wellness program with the recommendations or restrictions stated above.

Signed_____
Date_____ Phone_____