Flowery Vale Health & Fitness Center
For Mature Adults

204 S. South St.
Accident, MD 21520
301-746-8050

Medical Referral Form- Participation in Exercise Program

Healthcare Provider:

Patient Name: ____
Date of Birth: ___________________

Your patient has applied to participate in an exercise program offered by Flowery Vale Health and Fitness Center for mature adults. Active participation in this program requires medical clearance. Please fill in this form and indicate limitations, if any.

My patient may participate in the following activities to the level indicated.

Type of Exercise	Full Participation	Limited Participation	No Participation
Cardiovascular Exercises			
Bicycle			
Recumbent Bicycle			
Treadmill			
Elliptical			
Resistance Exercises: lbs/reps			
Chest			
Back			
Shoulders			
Arms			
Legs			
Stretches:			
Yoga Class			
Feldenkrais Class			
Water Aerobics			
Stability Ball Class			

Provider Comments:
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____
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Provider Signature: ____
Date:____________