



## PHYSICIAN'S APPROVAL FORM

Dear Doctor

I desire to start a new exercise program here in \_\_\_\_\_ called Stroller Strides®. The classes are taught along the most recent ACOG guidelines and are taught by nationally certified fitness instructors. The classes consist of Power Walking with the stroller, body toning and flexibility exercises. I would like your approval to begin this program. I thank you for your support in my health!

### PATIENT INFO

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Birthdate \_\_\_\_\_

Email Address \_\_\_\_\_

### PLEASE RETURN THIS FORM TO STROLLER STRIDES:

- Fax (insert number) \_\_\_\_\_
- Address
- Client will pick up at office

### TO BE COMPLETED BY PHYSICIAN

I give \_\_\_\_\_ my approval to participate in this program.  
Patient's name

Name of Physician \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

### A NOTE FROM STROLLER STRIDES...

Thank you in advance for supporting your client's desire to join Stroller Strides®. Should you have any questions, please don't hesitate to contact us. Additionally, please let us know if you would like further information on our program for your patients.