



## PRENATAL EXERCISE MEDICAL WAIVER

Please print, complete, and have your physician sign for consent to participate in this program. There is a \$5.00 registration fee for this six-week series. **The Birthing Suite, One Medical Center Drive, Biddeford, ME 04005**

### PERSONAL INFORMATION

Name:	Age:	Occupation:
Street Address:	Email Address:	
City:	State:	ZIP Code:
Home Phone:	Cell Phone:	Work Phone:
Person to Contact In Case of Emergency:	Home Phone:	Cell Phone:
Your Daily Activity Level: <input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> Sedentary		Baby#:
Doctor:		Due Date:

### MEDICAL HISTORY

Please check where applicable:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Respiratory Problems (ie: Asthma)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Seizures
<input type="checkbox"/> Backache	<input type="checkbox"/> Hip Problems	<input type="checkbox"/> Shoulder Problems
<input type="checkbox"/> Knee Problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Ankle Problems	<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Other _____

### PHYSICIAN SIGNATURE

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

Any concerns or limits regarding your patient's participation in this program?

No     Yes – Please Explain \_\_\_\_\_