STROLLER STRIDES®

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.