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: ❑ Heavy ❑ Moderate ❑ Light ❑ Sedentary		Baby#:
Doctor:		Due Date:

MEDICAL HISTORY

Please check where applicable:

❑ Heart Disease	❑ Diabetes	❑ Respiratory Problems (ie: Asthma)
❑ High Blood Pressure	❑ Fainting	❑ Seizures
❑ Backache	❑ Hip Problems	❑ Shoulder Problems
❑ Knee Problems	❑ Headaches	❑ Heartburn
❑ Ankle Problems	❑ Leg Cramps	❑ Other ____________________________

PHYSICIAN SIGNATURE

Name: ____ Date: ____

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

❑ No ❑ Yes – Please Explain ____

N-456 01-08