



AUTHORISATION TO EXERCISE

Please return the completed form and give to your Pilates Instructor or studio manager at your first class.

Client Details

Name:

Address:

Phone:

Email:

GP/Specialist Details

Name:

Address:

Phone:

Email:

Studio Location/s

Absolute contraindications:

Please inform us if the above client has/develops any of the following absolute contraindications to exercise during their pregnancy (please circle).

- | | |
|--|--------|
| ▪ Ruptured membranes | Yes/No |
| ▪ Preterm labour | Yes/No |
| ▪ Hypertensive - high blood pressure disorders of pregnancy | Yes/No |
| ▪ Incompetent cervix | Yes/No |
| ▪ Growth restricted foetus | Yes/No |
| ▪ Triplets or more | Yes/No |
| ▪ Placenta previa after 26 weeks | Yes/No |
| ▪ Persistent 2nd or 3rd trimester bleeding | Yes/No |
| ▪ Uncontrolled Type 1 diabetes, thyroid disease | Yes/No |
| ▪ Any other serious cardiovascular, respiratory or systemic disorder | Yes/No |

Relative contraindications:

Please inform us if the above client has/develops any of the following relative contraindications to exercise during their pregnancy (please circle).

- Previous miscarriages Yes/No
- Previous preterm birth Yes/No
- Mild/moderate cardiovascular disorder Yes/No
- Mild/moderate respiratory disorder Yes/No
- Anemia (HB \geq 8 weeks Yes/No Other significant medical conditions Yes/No

Warning signs:

Please advise your patient of any warning signs that exercise should cease immediately including:

- Vaginal bleeding
- Chest Pain
- Dyspnoea before exertion
- Muscle weakness
- Dizziness
- Calf pain or swelling
- Headache
- Onset of labour
- Decreased foetal movement

Additional Comments:

Recommendation:

Taking into consideration all the contraindications and warning signs listed on this form, do you recommend the above client to exercise during their pregnancy at ALIGN Pilates?

Yes/No

Date:

GP/Specialist Signature:_____

GP/Specialist Name_____

Date:

Client Signature:_____

Client Name_____

