



MEDICAL CLEARANCE for CONQUERING PELVIC PAIN Exercise Class

Dear Dr. _____:

Your patient, (name) _____, has signed up to participate in a pelvic pain exercise class, which will be taught at 731 Alexander Road, Suite 103, Princeton. All classes are taught by a Pelvic Physical Therapist. Activities included in this class may involve gentle movement and stretches, yoga postures, breathing techniques, mindfulness/relaxation and education topics focused on strategies that help to empower women experiencing Pelvic pain. Participants will exercise in various positions, standing, seated, mat work and can be modified based on participants' exercise tolerance and comfort level. These exercises will help increase flexibility, reduce pain, improve postural and breathing coordination and increase awareness of relaxation. Your patient has reported the following medical condition(s):

If there are no contraindications for exercise, or if contraindications or precautions are present, please respond accordingly:

_____ I give permission for my patient to participate in exercise class.

_____ I do not give permission for my patient to participate in exercise class.

_____ I give permission for my patient to participate in exercise class with the following restriction(s):

Physician's Name (printed) _____ Date: _____

Physician's Signature: _____

Physician's Address: _____

Physician's Phone Number: _____