

**MEDICAL FORM  
TO BE COMPLETED BY  
MEDICAL PRACTITIONER**

This is to certify that I am aware that

NAME .....

wishes to attend pregnancy or post-natal exercise classes conducted by a physiotherapist.

There is no significant medical reason that would prevent her participation.

DOCTOR'S SIGNATURE .....

Any comments .....

DATE .....

DOCTOR'S NAME .....

ADDRESS .....

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