# Medical Clearance Form

## Dear Doctor:

Your patient _____. wishes to take part in an exercise program and, or fitness assessment. the exercise program may include progressive resistannce training,frexibility exersices, and a cradiovascular program; increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, and muscular strength and endurance.
After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advise in setting limittations to their program. By completing this form, you are not assuming any responisbility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's recommendations).

## Patient's Consent and Authorization

I consent to and authorize_____. to release to _____, health information concerning my ability to participate in an exerercise program and/or fitness assessment. I understand this consent is revicable except to the extent action has of my health information is prohibited without specific written consent of person to whom it pertains.

| | |
|---|---|
| Member's Signature | Date |
| Trainer's Signature | Date |

# Physician's Recommendations

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| | I am not aware of any contraindicaions toward participation in a fitness program. |
| | I believe the applicant can participate, but unge caution because. |
| | The applicant should not engage in the following activities: |
| | I recommend the applicant not participate in the above fitness program. |

| | | |
|---|---|---|
| Physician's signature | | Date |
| Physician's name (Print) | Phone | Fax |
| Address | City | State & Zip |