

MEDICAL CLEARANCE FORM

Name of Patient _____ Date _____

Your patient wishes to take part in an exercise program and/or fitness assessment at or with _____ . After initial screening it has been determined that this individual requires physician consent prior to engaging in the exercise program and/or fitness assessments due to _____

The participant will engage in the following exercise programming and/or fitness assessments:

Exercise Programming

Muscular Strength
 Flexibility
 Muscular Endurance
 Cardiorespiratory Fitness
 Other*

Fitness Assessments

Muscular Strength
 Muscular Endurance
 Flexibility
 Body Composition
 Cardiorespiratory Fitness

*Explain: _____

Physician's Recommendations

Please indicate below for which of the following your patient is cleared to participate

Muscular Strength & Endurance Training and Assessment

Yes with no limitations Yes with limitations below No cannot participate

Limitations/ recommendations: _____

Cardiorespiratory Fitness and Assessment

Yes with no limitations Yes with limitations below No cannot participate

Limitations/ recommendations: _____

Flexibility Training and Assessment

Yes with no limitations Yes with limitations below No cannot participate

Limitations/ recommendations: _____

Signature of Physician/Primary Care Provider

Date

Printed Name of Physician/Medical Group

Please return this form to:

Street Address

City State Zip