Lauren Moreno 954.661.5033

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 resistance training, flexibility exercises, and a cardiovascular 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 advice in setting limitations to their program. By completing this form, you are not assuming any responsibility 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 to Release Health Information

I consent and authorize _____ to release to _____ health information concerning my ability to participate in an exercise and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Client's signature _____ Date _____

Trainer's signature _____ Date _____

Physician's Recommendations

☐ I am not aware of any contraindications to my patient's participation in a fitness program.

☐ I believe the applicant can participate, but urge caution because: _____

_____

☐ The applicant should not engage in the following activities: _____

_____

☐ I recommend that the applicant **not** participate in the above fitness program.

_____ _____
Physician's signature Date

_____ _____ _____
Physician's name (please print) Physician's Phone Number Physician's Fax Number

_____ _____ _____
Street Address City State and Zip Code