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Medical Clearance Form

Dear Doctor,

Your patient is interested in having a physical fitness assessment and following an exercise program developed by a certified fitness specialist / certified personal trainer. Before we conduct an assessment or develop an exercise program, we need your medical clearance due to the risk factor(s) described below. **Please indicate any restrictions, sign the form, and return it to us as soon as possible in an envelope that designates it is from your office for signature authentication purposes.** Thank you!

Tracy Walsh, Owner

Physician Information

Name _____

Phone _____

Fax _____

Address _____

_____

Patient Information

Name _____

Phone _____

Risk Factors

obesity	male over age 45	female over age 55	smoker
↑ blood pressure	diabetes	↑ cholesterol	
COPD or asthma	arrhythmia	family history of CVD	CVD

Comments/Restrictions _____

_____

_____

Examples:

- Blood pressure medication keeps heart rate response low.
- Do not allow push-ups or other activity that stresses thoracic cavity.
- Do not let heart rate go above 140 bpm.
- None
- No participation in assessment or exercise program

Physician Signature _____ Date ____/____/____