

Medical Clearance Form

Department of Sports and Recreation
Kennesaw State University
Attention: Fitness Coordinator
290 Kennesaw State University Road NW
Kennesaw, GA 30144
(470) 578-6913 (phone)
(470) 578-9198 (fax)

Date: _____

Dear Dr. _____,

Your patient _____ is interested in taking part in a Personal Training Program through the Department of Sports and Recreation at Kennesaw State University. The pre-screening process will involve testing of body composition, cardiovascular endurance, muscular endurance, muscular strength, and flexibility. The program will be administered by a certified personal trainer with current First Aid, CPR and AED credentials.

Your patient has completed a physical activity readiness questionnaire and health history questionnaire. Based on the information your patient provided through his or her Personal Training Registration packet and/or consultation, we are requesting medical clearance. By completing this form you are signifying that there are no medical reasons which preclude your patient from participating in the Personal Training Program through the Department of Sports and Recreation at Kennesaw State University. Please complete the following:

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

Please list any medications that your client is currently taking:

If your patient is taking medications that will affect his/her heart rate response to exercise, please indicate any effect (raises, lowers, has no effect on heart rate response):

____ The applicant has my approval to begin an exercise program with the recommendations or restrictions stated above.

____ Date when I would recommend patient follow up with me if necessary.

____ I would recommend that the applicant NOT participate in an exercise program. Physician's

Physician Name (Please Print) _____ Phone _____

Physician's Signature _____ Date _____

Client's Printed Name _____

TO BE COMPLETED BY PERSONAL TRAINING PATRON

____ (initial) I acknowledge that it is my responsibility to inform the Personal Training Specialist and/or Fitness Coordinator in writing if any of my medical or health information changes. I also acknowledge that it is my responsibility to follow up with my physician at the appropriate date if indicated above that I am advised to do so.

Personal Training Patron Name: _____

Personal Training Patron Signature: _____ Date: _____

Thank you for taking the time to complete this form