

STATEMENT OF MEDICAL CLEARANCE FOR EXERCISE

Participant's name: _____

Address: _____

Date of birth: _____

Physician's name: _____

Address: _____

Telephone number: _____

Conditions/Medications that may affect an exercise program: _____

- YES. My patient _____ has no current unstable medical problems that are a contraindication to participating in an exercise or resistance-training program. I approve of and support his or her participation in this progressive strength, endurance, balance, flexibility-training exercise program, and I have discussed the signs and symptoms that would make an exercise program unsafe. These symptoms are summarized as follows:

- NO. My patient _____ is not eligible to participate in the exercise program due to his or her current medical status.

Please indicate any special recommendations or specific comments:

Physician's signature

Date