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

_____ **Please return this form to:**
Printed Name of Physician/Medical Group

_____
Street Address

_____
City State Zip