MEDICAL CLEARANCE FORM

Dear Doctor,

Your patient _____wishes to take part in an exercise program. The exercise program may include progressive resistance training, flexibility exercises and a cardiovascular program that will increase in duration and intensity over time.

After completing a readiness questionnaire (PAR-Q) and discussing their medical conditions we agreed to seek your advice in setting limitations to their program. Please identify any recommendations or restrictions for your patient's fitness program below.

Patient's Consent and Authorization

I consent to and authorize _____to release to Francie Lloyd and Train for Life®, health information concerning my ability to participate in an exercise program. I understand this consent is revocable except to the extent action has 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**_____

Physician's Recommendations

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

_____

_____

_____

The applicant should not engage in the following activities:

_____

_____

_____

I recommend the applicant not participate in the above fitness program for the following reasons:

_____

_____

_____

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises or lowers heart-rate response):

_____
_____
_____

Type of Medication:

_____
_____
_____

Effect:

_____
_____
_____

Recommendations or restrictions:

_____
_____
_____

My patient has my approval to begin an exercise program with the recommendations or restrictions stated above.

Physician's Signature_____**Date**_____

Physician's Name (Print)_____

Phone_____

Address
City_____**State**_____**Zip**_____