Physician's Clearance for Exercise

Your patient _____ would like to begin an exercise program. After reviewing his/her responses to our Medical History Questionnaire, we would appreciate your medical recommendations concerning his/her participation in physical activity.

Client's Name _____ Phone_____

Reason for need of Medical Clearance_____

I _____ give permission to release any pertinent medical information from my medical records. All information will be kept confidential.

Client's Signature_____

Physician Use Only

It is my understanding that _____ will be participating in a fitness evaluation and/or exercise program.

Are there any recommendations or restrictions?_____

_____

_____

Please check one of the following statements:

- ☐ I concur with the aforementioned patient's participation with no restrictions.
- ☐ I do not concur with the aforementioned patient's participation with no restrictions.
- ☐ I concur with the aforementioned patient's participation in a fitness evaluation and/or exercise program if he/she restricts activities to:_____

Limitations_____

Physician's Name (printed)_____ Date_____

Physician's Signature_____Email_____

Street Address_____City_____State____

Phone_____ Fax_____