

PHYSICIAN'S CLEARANCE FORM



Health, Fitness & Wellness Solutions

Patient's name: _____ Date: _____

Age: _____ Date of last physical examination: _____

_____ This patient may participate fully in a physical activity program consisting of cardiovascular, strength, and flexibility training without limitation.

_____ This patient may participate in a physical activity program with the following limitations and/or recommendations:

Please include a brief description of any medical condition that might affect his/her physical activity program:

If this patient is on any medication that may affect the heart rate or the blood pressure response to exercise (elevating or suppressing), please indicate:

I consider the above individual to be:

- _____ normal
- _____ cardiac patient
- _____ prone to coronary heart disease
- _____ other (explain)

Please fill in the following information if available:

- _____ result of last GXT
- _____ blood pressure
- _____ glucose
- _____ total serum cholesterol
- _____ HDL-C _____ LDL-C
- _____ triglycerides

Physician's Name _____

Address: _____

Phone Number: (_____) _____

Fax Number: (_____) _____

Physician's Signature _____ Date _____

