Physician's Clearance Form

Please return this form to: _____
(Personal Fitness Trainer's Name)

Address: _____

Phone: _____

Date: _____

Patient's name: _____ Age: _____

Date of last physical examination: _____

_____ This patient may/may not 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 Signature _____ Date _____

Please Note: This record must be signed by the physician or at least stamped by the physician and verified if stamped by a typed letter on the provider's letterhead. THE PHYSICIAN'S CLEARANCE FORM WILL NOT BE ACCEPTED WITHOUT SUCH PROPER VERIFICATION.