



## STATEMENT OF MEDICAL CLEARANCE FOR EXERCISE

Participant's name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Physician's name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

A previous exercise or rehabilitation program has been established for this patient.

Guidelines are attached or are as follows:

☐ YES. My patient \_\_\_\_\_ has no current unstable medical problems that are a contraindication to participating in an exercise or resistance-training program. I approve of and support his or her participation in this progressive strength, endurance, balance, flexibility training exercise program, and I have discussed the signs and symptoms that would make an exercise program unsafe. These symptoms are summarized as follows:

☐ NO. My patient \_\_\_\_\_ is not eligible to participate in the exercise program due to his or her current medical status.

Please indicate any special recommendations or specific comments:

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Date