#  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**