PHYSICIAN'S CLEARANCE FORM

To be completed by patient:

Patient's Name _____ Phone (____) ____ _____

Address _____ City _____ State_____ Zip _____

I hereby authorize my physician to complete and forward this form to:

_____

and supply the information requested herein.

_____
Patient's Signature

To be completed by physician:

I have examined this patient on _____
Date of Last Examination

I have found the following:

☐ She/he may participate fully in a physical activity program consisting of cardiovascular, strength and flexibility training without restrictions or limitations.

☐ She/he may participate fully in a physical activity program with the following limitations or restrictions:

_____

_____

If your patient is on any medication which may affect heart rate, blood pressure (elevating or suppressing) or otherwise affect response to exercise please indicate such effects and/or limitations/restrictions.

_____

Please indicate any limitations/restrictions placed on this patient due to any disabilities or communicable diseases.

_____

Physician's Signature:_____ Date:_____

PLEASE NOTE: This record must be signed by the physician granting the clearance.

_____
Patient's Signature or Guardian's Signature if the participant is under 18 years of age