

Physician's Clearance Form

Date: _____

Patient's name: _____ Age: _____

I have examined _____ on _____.
(Client's name) (Date of last exam)

I have found the following:

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

She/he may participate in a physical activity program with the following limitations (please include a brief description of any medical condition that might affect his/her program). _____

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

Please fill in the following information if available:

Result of last GXT: _____
Blood pressure: _____
Glucose: _____
Total serum cholesterol: _____
HDL-C: _____
Triglycerides: _____

Physician's Signature: _____ Date: _____

Please Note: This record must be stamped with a physician's official stamp or be accompanied by a typed letter on a physician's letterhead, documenting that medical evaluation has been performed on the named client. **THE PHYSICIAN'S CLEARANCE FORM WILL NOT BE ACCEPTED WITHOUT PROPER VERIFICATION.**

Please mail to:
1100 College St. W-40
Columbus, MS 39701
Attention: Betsy Spencer

Or FAX to:
(662) 241-7489
Attention: Betsy Spencer

