

BODYCENTRIC FITNESS - MEDICAL CLEARANCE FOR EXERCISE

Participant's name: _____

Address: _____

Date of birth: _____

Diagnosis: _____

Physician's name: _____

Address: _____

Telephone number: _____

- I _____ give permission for Dr _____ to
release medical information to _____ (personal trainer).

Signature: _____

- An exercise program has been established for this participant. Guidelines are as follows:
- YES. My patient _____ may fully take part in a physical fitness program including aerobic, muscular strength, and flexibility training without restrictions.
- NO. My patient _____ may not take part in a physical fitness program as described above.
- My patient _____ may take part in a physical fitness program as described above with the following recommended restrictions.

Physician Signature: _____ Date: _____

