

Physician's Clearance Form

Participant's Name: _____

Today's Date: _____

Special Note*

This individual would like to participate in a fitness program being offered by the company known as Fit2Be. We are concerned by your patient's medical history and/or symptoms indicated below. Due to your knowledge of your patient's health history, we feel that it is appropriate for you to suggest the level of exercise from which you feel this individual may begin to progress in a self-directed manner. Please be aware that this fitness company is not medically supervised; therefore we will not be responsible for providing special supervision/or monitoring your patient's exercise program or their adhere recommendations. Our professional staff is certified to administer CPR, AED and First Aid in an event of an emergency.

Please complete the "Physician Clearance Recommendations Form" attached to this form and return it back to the individual or fax/mail it to the company.

Your Patient Has Indicated He/She:

Has had a Heart Attack, Stroke, or Heart Surgery

Has Cardiovascular, Pulmonary, Metabolic or other significant diseases

Has pains or pressure in the Chest area, Neck, Shoulder or Arm during or right after exercise

Has experienced unusual Leg Pain upon exertion

Has a Heart Murmur or Irregular Heart beat

Has Insulin-Dependant Diabetes or takes Medication to control his/her blood sugar

Has experienced Shortness of Breath at rest or with mild exertion

Has experienced Dizziness/Fainting Spells at rest or with exertion

Is currently pregnant or within six weeks postpartum. (# of months pregnant ___)

Is taking Prescription Medication for a medical condition that may impact his/her ability to exercise

Has a Chronic or Acute Orthopedic or other health condition that could be made worse by physical activity

Has a Medical Condition not mentioned above which might affect his/her ability to participate in an exercise program (i.e., Bursitis, Arthritis, Knee Injury, Emphysema, Asthma, etc.)

Has a male family member under the age of 55 or a female family member under the age of 65 who has a history of Cardiovascular Disease

Has High Blood Pressure (>140/90) and/or is on Medication for Blood Pressure

Is a male over the age of 45

Is a female over the age of 55, or Post-Menopausal, or had a Hysterectomy

Has a BMI greater than 30 or waist girth > 100cm

Has a total Serum Cholesterol >200mg/dl and/or has been diagnosed with High Cholesterol

Currently smokes cigarettes or smoked within the last 6 months

Accumulates less than 30 minutes of physical activity most days of the week at work or during recreational pursuits

Medical Recommendations (To be Completed By Physician)

1. Is all exercise contraindicated? Yes No

If yes, please explain: _____

2. Is body fat reduction recommended? Yes No

3. Is cardio-respiratory conditioning recommended? Yes No

4. Do you recommend a maximum heart rate or MET level not to be exceeded during exercise? Yes No

If yes, please explain: _____

5. Are there any contraindications to flexibility training? Yes No

6. Are there any recommendations or restrictions concerning possible use of any of the following equipment or sub-maximal fitness testing described below:

	Recommended	Restrict		Recommended	Restrict	
Floor Exercise/Group Exercise			Weight Training Machines			
Treadmill			Stair Climber			
Free Weights			Outdoor Running			
Stationary Bicycle			Outdoor Walking			
Elliptical Cross-Trainer			Rowing Machine			

Do you recommend a Fitness Assessment? Yes No

Please explain any recommendations or restrictions: _____

If you have any questions concerning the above, please call: _____

Physician's Name: _____ Signature: _____

Address of Medical Office/or Hospital: _____

Phone: _____ Today's Date: _____

For Company Use Only:

Medical Recommendation Review: I certify that I have reviewed, understand, and will comply with all of my physician's recommendations and restrictions as they pertain to my exercise program and participation during the use of all other company services used. I also acknowledge I have received a copy of these recommendations.

Client's Signature _____

Date: _____

Fitness Staff _____

Date: _____