

Medical Clearance Form

Dear Doctor _____:

Your patient _____, wishes to start a personalized training program with me which requires your medical clearance prior to participation. Clearance indicates that this patient has no contraindications for participation in the below-described one-on-one fitness training and health assessments. The activities will involve the following:

- A low intensity aerobic training program, eventually increasing both the intensity and time.
- An introduction to resistance and weight training exercises. Our goal is to build up to 2 to 3 exercises for each major muscle group over a 6 week period.
- Teach proper stretching and flexibility exercises for all major muscle groups.
- Develop better balance & coordination skills/posture & body alignment.

If your patient is taking medications that will affect his/her heart rate response to exercise, please indicate the manner of the effect (raises, lowers or has no effect on heart rate response):

Type of medication: _____

Effect: _____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program: _____

How often is your patient prescribed to exercise per week? _____

Explain _____

Signature _____ Date _____ Phone _____

I _____, hereby authorize my physician to release the above information to Carol C. Phillips, Certified Personal Trainer for purposes for furthering my physical wellness.

Patient's Name