# Physician's Clearance Form

Please return this form to: _____

(Personal Trainer's name) _____

Address: _____

Phone: _____

Date: _____

Patient's name: _____ Age: _____

Date of last physical examination: _____

_____ This patient may participate fully in a physical activity program consisting of cardiovascular, strength, and flexibility training without limitation.

_____ This patient may participate in a physical activity program with the following limitations and/or recommendations:_____

Please include a brief description of any medical condition that might affect his/her physical activity program:

_____

_____

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

I consider the above individual to be: _____ normal

_____ cardiac patient

_____ prone to coronary heart disease

_____ other (explain)

Please fill in the following information if available:

result of last GXT

blood pressure

glucose

total serum cholesterol

HDL-C LDL-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 a medical evaluation has been performed on the named client. THE PHYSICIAN'S CLEARANCE FORM WILL NOT BE ACCEPTED WITHOUT SUCH PROPER VERIFICATION.

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or

Email me at weightlossking40@gmail.com to *request*

this **form** in Microsoft Word format.

This format allows you to easily change the words to fit

your fitness program.