Medical Clearance Form

Dear Doctor:

During application for enrollment at the Fitness Center, **your patient** _____ completed a Health History and Activity Profile Form. Information on this form indicates your patient will require a physician's clearance form. The patient has **indicated the following health risk(s):**

_____

_____

HealthFit Exercise Specialist/Personal Trainer(print) _____

The patient's exercise program will take place in HealthFit, and will be administered by qualified personnel trained in conducting exercise programs. If you know of any medical, or other reasons, why participation in the Fitness Center by the applicant would be unwise, please indicate so on this form. By completing the form below you are not assuming any responsibility for your administration of the exercise program.

REPORT OF PHYSICIAN (*Please check one*)

□ I know no reason why the applicant may not participate.

□ I believe the applicant can participate, but I urge caution because: (*Please list limitations*)
_____
_____

□ The applicant should not engage in the following activities:
_____
_____

□ I recommend that the participant NOT participate.

Information other than what is requested is also greatly appreciated. Thank you in advance for your recommendations and support of this individual.

_____

_____

Print Physician Name _____ Fax# _____
Physician's Signature _____ Date _____
Address _____ Phone _____
City and State _____ Zip Code _____

MEDICAL RECORDS RELEASE AUTHORIZATION

I give permission to release any medical information that may be beneficial for preparing an exercise program to HealthFit.
Patient Signature _____ Date _____

Patient Name _____

Please return Medical Clearance Form to:
HealthFit: Powered by Sarasota Memorial
5880 Rand Blvd. Suite 102
Sarasota, FL 34238
Phone: (941) 917-7000
FAX: (941) 917-7478