



## Medical Clearance Form

Dear Doctor,

Your patient \_\_\_\_\_ wishes to take part in an exercise program and/or fitness assessment at the University of Chicago. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program that will increase in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of the body composition, flexibility, and muscular strength endurance.

After completing a readiness questionnaire and discussing their medical conditions we agreed to seek your advice in setting limitations to their program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

### Patient's Consent and Authorization

I consent to and authorize \_\_\_\_\_ to release to The University of Chicago's Personal Training Staff, health information concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Member's signature	Date
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### Physician's Recommendations

Please check one and explain if necessary:

<input type="checkbox"/>	I am not aware of any contraindications toward participation in a fitness program.
<input type="checkbox"/>	I believe the applicant can participate, but I urge caution because:  
<input type="checkbox"/>	The applicant should <b>not</b> engage in the following activities:  
<input type="checkbox"/>	I recommend the applicant <b>not</b> participate in the above fitness program for the following reasons:  
If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers heart-rate response). Type of Medication:	
Effect:	
Recommendations or restrictions:	

My patient, _____ has my approval to begin an exercise program with the recommendations or restrictions stated above.		
Physician's signature	Date	
Physician's name (print)	Phone	
Address	City	State/Zip