



Medical Clearance Form

Participant's Name: _____

Address: _____

Date of Birth: _____

☐ **Yes!** My patient, _____ has no current unstable medical problems that are a contradiction to participating in an exercise or resistance – training program. I approve of and support his or her participation in a progressive strength, balance, and flexibility – training exercise program.

Comments:

☐ **No.** My patient, _____ is not eligible to participate in the exercise program due to his or her current medical status.

Comments:

Please indicate any special recommendations or specific comments:

Physician's signature _____ Date _____

Physician's name (print) _____ Phone _____

Address:
