Medical Clearance Form

Date: ____/____/____

I, _____hereby authorize the release of any medical history deemed necessary in order to begin a training program at _____.

(Requested by the Provisions Privacy Act) Signature: _____

I am particularly concerned about the following:

_____
_____
_____
_____

Please describe below any recommendations / restrictions that you feel should be addressed in an exercise program:

_____
_____
_____
_____

If your patient is taking any medication that may cause any contraindications to exercise please indicate below.

Type of medication:	Effect:
_____	_____
_____	_____
_____	_____
_____	_____

Doctor's name: _____Signature:_____

Clinic: _____Address:_____

_____State:_____Post code: _____

Phone: _____

Thank you for taking the time to complete this form.

Regards_____ (Gym Instructor)