

# MEDICAL CLEARANCE FORM



DATE : \_\_\_\_\_

PATIENT : \_\_\_\_\_

RE : \_\_\_\_\_

DEAR DR. \_\_\_\_\_ :

This form is designed to ensure safe participation in a submaximal fitness program which may include strength and flexibility exercises. From your knowledge of this patient, should there be any restrictions on the amount or type of physical activities in which he or she participates?

RESTRICTIONS (PLEASE ENTER NONE IF NO RESTRICTIONS APPLY)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DOCTOR'S  
SIGNATURE : \_\_\_\_\_

DATE : \_\_\_\_\_

THANK YOU FOR COMPLETING THIS FORM .

Please return by confidential fax to: **Kristy Webster Rehabilitation & Fitness Programmer**  
FAX : (250) 474-8650 PHONE: (250) 474-8617