Physician's Clearance Form

Date: ____________

Patient's Name: ________________________

Age: _________

Below to be filled out by the Physician:

Date of last physical examination: ______________________

This patient, ______________________________ may participate in a physical activity program consisting of cardiovascular, strength and flexibility with the following limitations/ recommendations:

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The patient should renew this form in (please check):

______ 3 months ______ 6 months ______ 1 year

Signature of Physician: ____________________________

Physician's Name (please print): ______________________________

Address: ____________________________________

City: _______________________ State: _____________ Zip: ________

Signature of Patient or Guardian: ______________________________