Medical Clearance Form Client: _____
Physician: _____
Telephone: _____

Dear Physician: Please provide the following information to assist my trainer in implementing my physical exercise program. Please verify this record with your signature along with your official stamp. Thank you.

Client signature: _____
Date: _____

The client may fully take part in a physical fitness program including aerobic, muscular strength, and flexibility training without restriction. _____ The client may take part in a physical fitness program as described above with the following recommended restrictions (please briefly note any special concerns or precautions you advise). _____ The client may not take part in a physical fitness program as described above. If the client uses any medication which may reduce exercise tolerance or alter heart rate or blood pressure response during exercise, please note: If this patient's training heart rate should differ from that normally recommended for adults of the same age, please indicate the correct range (or, when applicable, note if THR values should be obtained from the patient's rehab center team):

Physician Signature: _____
Date: _____

*Such a program may include or gradually build up to: training sessions lasting approximately 1 hour on 3-5 days per week; progressive resistance exercise using no weights or light hand weights and, in some cases, gradually building up to moderate intensity training with variable resistance exercise machines; moderate lowimpact aerobic training such as walking, stationary cycling, aqua class, or low-impact dance class at ageadjusted training intensities predicted to produce cardiovascular benefits. (All programming to be administered only as is apparently well tolerated).