



MEDICAL CLEARANCE FORM

Name: _____ Date: _____

Note to Physician: This individual would like to participate in a fitness program offered by Safari Island Community Center however, the individual has indicated health history information that precludes Safari Island Community Center from allowing him/her to participate in the fitness program without your consent and recommendations, if any. Please complete the Medical Recommendations section below and return this form to the individual at your earliest convenience.

Description of Program

If admitted to the health and fitness program, the individual will be given the option of completing an assessment of his or her current fitness level by completing a Full Fitness Assessment, consisting of a series of non-diagnostic assessments that may include the measurement of an individual's resting heart rate and blood pressure, body composition, flexibility, cardio-respiratory conditioning, muscular strength and endurance.

Based on these tests, the participant's Health History information, and your recommendations, if any, an exercise program will be developed for the individual. A typical fitness program may include the following:

- 5 to 10 minute warm-up (light exercise and stretching)
- 10 to 45 minute aerobic activity (running, walking, stair stepping, bicycling, etc.)
- 10 to 30 minute strength training (resistance machines, free weights, floor exercises)
- 5 to 10 minute cool-down (stretching and flexibility activities)

HEIGHT:	LUNGS: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
WEIGHT:	HEART: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
RESTING HEART RATE:	MUSCULOSKELETAL: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
CHOLESTEROL LEVEL:	COMMENTS:

Medical Recommendations: Check one recommendation option below and complete associated questions, if any.

- This individual may NOT participate in the fitness center program based on the following limitations:
- This individual may participate without restriction in all fitness center activities.
- This individual may participate in the fitness center program with the following limitations:

What is the maximum heart rate this individual should not exceed during aerobic exercise other than what is recommended for the participant's age and fitness level? _____ Please specify beats per minute: _____

The following program(s) are recommended (check all that apply):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Nutrition analysis | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Pre/Post-natal exercise | <input type="checkbox"/> Flexibility improvement |
| <input type="checkbox"/> Muscle strengthening | <input type="checkbox"/> Aerobic conditioning | <input type="checkbox"/> Back care | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Blood pressure monitoring | <input type="checkbox"/> Other: | | |

Physician Information

_____ Last Name	_____ First Name	_____ Signature	_____ Phone
_____ Address	_____ City	_____ State	_____ Zip