FITNESS CENTER
PHYSICIAN'S MEDICAL CLEARANCE FORM

Name:____________________________________ (member's name) has requested use of the Letchworth Central School District's fitness room. The physician's receipt of this form is hereby acknowledged by the physician's signature below. If you know of any medical reason why participation by the applicant would be unwise, please indicate so on this form. If you have any further questions about the facility, its equipment or activities, please call the Letchworth Central Athletic Director at 493-3511.

PHYSICIAN REPORT

I, ____, (*physician's name, please print*)

give my consent for ______________________________ (*member's name*) to use the Letchworth Central School District's fitness room and participate in its exercise activities.

Specific Recommendations:

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Physician Signature:___________________________________ Date:_______________

Physician Address: ____________________________________

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Physician Phone Number:_______/_______/__________

Updated 7/12/21

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