

MEDICAL CLEARANCE FORM

Forever Fit Fitness Center

Ellington Senior Center

Patient's Name: _____

Address: _____

Email: _____

Phone: _____

Please complete the following for the above patient's initial application to participate in an exercise program:

1. Health History:

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Pulmonary |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> CVD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Other |

Please explain checked items if necessary:

2. Medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Please indicate any specific guidelines or limitations for this patient?

4. Approval:

I approve this applicant for her/his participation in the Forever Fit exercise program:

PHYSICIAN'S SIGNATURE: _____

PRINTED NAME: _____

PHONE: _____ **DATE:** _____