

Balanced By Fitness
Personal Training Program
Physician's Exercise Clearance Form

Date: _____

Patient: _____

Patients Home # _____ wk # _____

DOB: _____ Sex: _____ Age: _____

Date of last Physical Examination: _____ Weight: _____ Height: _____

This patient may participate in a physical activity program with the following limitations and/or recommendations: _____

Please include a brief description of any medical conditions that may affect his/her physical activity: _____

List medications taken regularly, and for what conditions

Medicine

Reason

I consider the above individual to be:

_____ Normal

_____ Cardiac Patient

_____ prone to Coronary Artery Disease

_____ Other(explain) _____

Please fill in the following information if possible:

Blood Pressure _____ Glucose _____

Total serum Cholesterol _____ HDL-C _____ LDL-C _____ Triglycerides _____

Please Note: This record must be stamped with a physician's stamp or be accompanied by a typed letter on a physician's letter head, documenting that a medical evaluation has been performed for the named client. The Physician's Clearance Form WILL NOT BE ACCEPTED WITHOUT SUCH PROPER VERIFICATION.

Physician Signature _____

Date _____

Physician's Phone Number _____