



# Medical Clearance Form

Dear Doctor:

During application for enrollment at the Fitness Center, **your patient** \_\_\_\_\_ completed a Health History and Activity Profile Form. Information on this form indicates your patient will require a physician's clearance form. The patient has **indicated the following health risk(s)**:

\_\_\_\_\_  
\_\_\_\_\_

HealthFit Exercise Specialist/Personal Trainer(print) \_\_\_\_\_

The patient's exercise program will take place in HealthFit, and will be administered by qualified personnel trained in conducting exercise programs. If you know of any medical, or other reasons, why participation in the Fitness Center by the applicant would be unwise, please indicate so on this form. By completing the form below you are not assuming any responsibility for your administration of the exercise program.

**REPORT OF PHYSICIAN** *(Please check one)*

- I know no reason why the applicant may not participate.
- I believe the applicant can participate, but I urge caution because: *(Please list limitations)*

\_\_\_\_\_

- The applicant should not engage in the following activities:

\_\_\_\_\_

- I recommend that the participant NOT participate.

Information other than what is requested is also greatly appreciated. Thank you in advance for your recommendations and support of this individual.

\_\_\_\_\_

Print Physician Name \_\_\_\_\_ Fax# \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City and State \_\_\_\_\_ Zip Code \_\_\_\_\_

**MEDICAL RECORDS RELEASE AUTHORIZATION**

I give permission to release any medical information that may be beneficial for preparing an exercise program to HealthFit.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

**Please return Medical Clearance Form to:**  
HealthFit: Powered by Sarasota Memorial  
5880 Rand Blvd. Suite 102  
Sarasota, FL 34238  
Phone: (941) 917-7000  
**FAX: (941) 917-7478**