**Medical Clearance Form** 

**Medical clearance form**

Crow Agency

Dear Doctor,

Your patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_wishes to take part in an exercise program and/or fitness program with the SDPI Healthy Heart Program/Crow Creek Wellness Center. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program that will increase in duration and intensity over time. The fitness assessment may include a sub maximal cardiovascular fitness test and measurements of the body composition, flexibility, and muscular strength endurance.

After completing a readiness questionnaire and discussing their medical conditions we agreed to seek your advice in setting limitations to their program. Please identify any recommendations or restrictions for your patient’s fitness program below (Physician’s Recommendations).

**Patient’s Consent and Authorization**

I consent to and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release the health information concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has been taken. Authorization is not valid beyond one

year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

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

Member’s signature Date

**Physician’s Recommendations:**

Please check one and explain if necessary:

\_\_\_\_\_\_I am not aware of any contraindications toward participation in a fitness program.

\_\_\_\_\_\_I believe the applicant can participate, but I urge caution because:

\_\_\_\_\_\_The applicant should **not** engage in the following activities:

\_\_\_\_\_\_I recommend the applicant **not** participate in the above fitness program for the following reasons:

\_\_\_\_\_\_If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers heart rate response).

Type of Medication:

Effect:

Recommendations or restrictions:

My patient,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, has my approval to begin an exercise program with the recommendations or restrictions stated above.

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

Physician’s signature Date