



**Medical Clearance Form**



Dear Doctor: Your patient \_\_\_\_\_ wishes to take part in an exercise program and/or fitness assessment at the Nash County Senior Center. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a flexibility, muscular strength and endurance assessment. All members will go through an orientation in the fitness room. After the orientation they will exercise at their own risk, although fitness trainers are available at scheduled times.

After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advice in setting limitations to their program. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

If you have any questions, please contact The Nash Senior Center at 252-459-7681.

**Patient's Consent and Authorization**

I consent to and authorize \_\_\_\_\_ to release to \_\_\_\_\_ Nash County Senior Center \_\_\_\_\_, 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 already been taken. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Member Signature:	Date:
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**Physician's Recommendations**

	I am not aware of any contraindications toward participation in a fitness program.	
	I believe the applicant can participate, but urge caution because:	
	The applicant should not engage in the following activities:	
	I recommend the applicant <b>not</b> participate in the above fitness program.	
Physician's signature		Date
Physician's name (print)	Phone	Fax
Address	City	State & Zip