Physician Medical Clearance Form

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Date: ___/___/___

Doctor's Name:_____

Your patient, _____, DOB ____/____/_____wishes to participate in Fight Back UH20 aquatic exercise program. The aquatic exercise program may include shallow water exercise, core strength, balance and agility, lower and upper extremity strength, plyometrics, flexibility, stretching & relaxation.

PHYSICIAN'S RECOMMENDATION

☐ I am not aware of any restrictions to participate in this exercise program.

☐ I believe the patient can participate but would urge caution (please explain): _____

_____

☐ Patient should not engage in the following activities: _____

_____

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on heart rate response during exercise):

Type of medication _____ Effect _____
Type of medication _____ Effect _____
Type of medication _____ Effect _____

PHYSICIAN COMPLETES

_____ (Patient's Name) has my approval to begin Fight Back UH20 exercise program with the recommendations or restrictions stated above.

Printed name _____ Phone _____

Signature _____

RETURN TO

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