



# Physician Medical Clearance Form

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Date: \_\_\_/\_\_\_/\_\_\_ Date of Parkinson's Diagnosis \_\_\_/\_\_\_/\_\_\_

Doctor's Name: \_\_\_\_\_

Your patient, \_\_\_\_\_, DOB \_\_\_/\_\_\_/\_\_\_ wishes to participate in the Rock Steady Boxing (NON-CONTACT) exercise program. The activity will involve cardiovascular training (jumping rope, running, punching heavy bags), flexibility instruction (stretching, getting up and down on the floor), resistance training and core strengthening techniques. Participants can attend up to five classes per week that are ninety minutes in duration. Participants can reach up to 90 percent of their maximum heart rate.

## 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 the Rock Steady Boxing exercise program with the recommendations or restrictions stated above.

Printed name \_\_\_\_\_ Phone \_\_\_\_\_

Signature \_\_\_\_\_

### RETURN TO

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