STATEMENT OF MEDICAL CLEARANCE FOR EXERCISE

Participant's name: _____ DOB:_____

Address: _____

Diagnosis: _____

Health Care Provider's name: _____Phone number: _____

Address: _____

Your patient, _____, has asked to participate in the BFC Ministry fitness program offered at Trinity United Methodist Church of Tallahassee, FL.

This program requires medical clearance for anyone who 1) has answered "yes" to any one of the questions on the Health History/Physical Activity Questionnaire (PAR-Q) or 2) is over 40 years of age and has not been involved in an exercise program on a regular basis; or 3) is recovering from surgery or a medical procedure, an extended illness or recent hospitalization, or has recently received physical, occupational or speech therapy.

Your patient will be involved in an exercise program that will be based on the ACSM's standards for exercise for healthy individuals or those who have medical clearance to exercise. He/She will be participating in cardiovascular exercise, strength training, and flexibility exercise during their class which may be in person, virtual or recorded format, and may also be off site.

Please provide the information below:

- YES. My patient _____ has no current unstable medical problems that are a contraindication to participating in an exercise or resistance-training program. I approve of and support his/her participation in this progressive strength, endurance, balance, flexibility-training group exercise program, and I have discussed the signs and symptoms that would make an exercise program unsafe. Should the participant experience any of the following symptoms they should immediately stop exercising:
  _____
  _____
  _____

- NO. My patient _____ is not eligible to participate in the exercise program due to his/her current medical status.

Please indicate any special recommendations, provide specific comments and/or list contraindicated exercises:

_____
_____
_____

_____ _____

Physician or Health Care Provider's signature Date