Medical Clearance for Personal Training

Date: ______________________

Dear Dr. _________________________________,

Your patient, ___________________________________ is interested in taking part in a personal training program at our facility. The pre-screening process will involve testing of body composition, cardiovascular endurance, muscular endurance, muscular strength, and flexibility. All assessments will be administered by a certified personal trainer qualified in assessment techniques, First Aid, CPR, and AED.

Your patient has completed a physical activity readiness questionnaire and has demonstrated concern for medical clearance. By completing this form, you are signifying any medical limitations necessary for your patient to participate in a personal training program. Please fill out the following:

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

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Please list any types of medication that your patient is taking that might affect their heart-rate response to exercise; or have any other side effect which might result in injury during or after exercise. Please indicate any effect (raises heart rate response, no effect, may cause dizziness or drowsiness, etc.)

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_____ The applicant has my approval to begin an exercise program with the recommendations or restrictions stated above.

_____ I would recommend that the applicant NOT participate in an exercise program.

Physician's Signature________________________ **Date:** _________________ **Phone:** ________________

Client's Printed Name _________________________

Thank you for taking the time to fill this out.

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