

PHYSICIAN'S CLEARANCE FORM

Please return this form to:

Advantage Personal Training I
11 Main Street
Mystic, CT 06355
860-245-0388 (Office)
860-245-0488 (Fax)

Advantage Personal Training II
5 Freedom Way C6
Niantic, CT 06357
860-691-1616 (Office)
860-691-1119 (Fax)

Date _____

Patient's Name _____ Date of Birth _____

Date of last physical examination _____

_____ This patient may participate in a physical activity program consisting of cardiovascular, strength, and flexibility training without limitation.

_____ This patient may participate in a physical activity program with the following limitations and/or recommendations:

Please include a brief description of any medical condition(s) that might affect his/her physical activity program:

If this patient is on any medication that may affect the heart rate or the blood pressure response to exercise, please indicate elevate or suppress:

I consider the above individual to be:

- _____ Apparently Healthy
- _____ Cardiac Patient
- _____ Prone to Coronary Heart Disease
- _____ Other (Please explain on back)

Physician's Signature

Date

Please print physician's name and address

Name _____ Address _____
City _____ State _____ Zip _____ Phone _____