# MEDICAL CLEARANCE FORM

**FITNESS THERAPY HAWAII**

**Dear Physician,**

Your patient wishes to begin a physical fitness program based on the NASM and PWR standards for exercise. The program may include moderate to vigorous cardiovascular/cognitive exercises, strength training, and flexibility/balance exercises. According to the medical history provided by the patient, risk factors for heart disease or metabolic syndrome and musculoskeletal injuries may preclude the patient from participating in some or all activities without clinical supervision. Your evaluation of the patient and recommendations for a physical fitness program development are requested. Thank you for your attention to this matter and helping your patient improve overall health and wellness.

**Description of Program:** Before beginning the exercise program, each individual meets with a qualified fitness professional to discuss the individual's health history and program goals and obtain measurements of resting heart rate, blood pressure, height, and weight. This information aligns with your recommendations to develop an exercise program that includes current digital fitness technology. Polar Heart Rate Monitors for cardiovascular fitness. An Inbody body analysis scanner to obtain composition/lean mass—professional Posture Analysis Screening and Evaluation Software to capture images and assess postural disturbances or imbalances.

PATIENT'S NAME                                                          (     )
                                                                       PATIENT'S PHONE NUMBER

PHYSICIAN'S NAME                                                       (     )
                                                                       PHYSICIAN'S PHONE NUMBER

PHYSICIAN'S ADDRESS (STREET, CITY, ZIP)

## I have been treating this patient since _____ with the following condition(s):

- ☐ Back Pain
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism

- ☐ Joint Pain
- ☐ Movement Disorders
  - *Please list the types:* _____
  - _____

- ☐ Obesity
- ☐ Other:_____
- ☐ Orthostatic Hypotension
- ☐ Osteopenia

- ☐ Osteoporosis
- ☐ Parkinson
- ☐ Parkinsonism

## He/she is cleared for exercise with:     ☐ **Limitations** *(see notes below)*     ☐ **No Limitations**

_____

_____

_____

## Please list any prescribed medications <u>and</u> any contraindications to exercise:

_____

_____

PHYSICIAN'S SIGNATURE                                                  DATE

Please email the completed form to: *georgema@fitnesstherapyhawaii.com*

**FITNESS THERAPY HAWAII**   **NASM**   **Exercise is Medicine**   **PWR!Moves CERTIFIED INSTRUCTOR**   **PWR!Moves CERTIFIED THERAPIST**