Personal Training Medical Clearance Form

Physician Information:

Name :	
Address:	
Phone:	

Notice of Clearance for Exercise Program:

I have examined _____ on _____.
(client's name) (date of last exam)

I have found the following:

____ He/she may participate fully in a physical activity program consisting of cardiovascular, strength, and flexibility training without limitation.

____ He/she may participate in a physical activity program with the following limitations (please specify limitations/modifications and provide a brief description of any medical condition(s) which may affect his/her program):

If your patient is on any medication which may affect the heart rate or blood pressure response to exercise (elevating or suppressing), please indicate ((Include name of medication and possible effect):

Medication	**Possible Effect**

Physician's Name:	
Physician's Signature:	