

## Medical Clearance

I, \_\_\_\_\_, grant Every Body Fit (d.b.a. FitForce) to request Medical Clearance from my physician \_\_\_\_\_.

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Doctor,

Your patient wishes to participate in exercise and resistance training programs with Every Body Fit. The physical activities your patient may engage in include the use of aerobic exercise, resistance training, stability training, exercise bands and/or tubes, and flexibility training. Your patient has answered "yes" to some questions on the Physical Activity Readiness Questionnaire.

### Indicate Questions

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If your patient is taking medications that will affect his or her heart rate response to exercise, please indicate the manner of the effect.

**Medication** \_\_\_\_\_

**Effect** \_\_\_\_\_

Please indicate any recommendations or restrictions that are appropriate for your patient during aerobic exercise, resistance training, and/or flexibility training.

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My patient \_\_\_\_\_ is cleared by me to perform aerobic exercise, resistance training, and/or flexibility training through the personal training program offered by Every Body Fit with the recommendations and restrictions above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return this form to Every Body Fit:**

**2668 FM 522, Brazoria, TX 77422**

**Fax: 979-345-4144**

**Phone: 979-997-3294**