Sample Medical Clearance Form

Exercise is Medicine® | AMERICAN COLLEGE of SPORTS MEDICINE®

Your patient _____ (Name of Participant) would like to participate in the exercise/fitness programs at _____ (Facility Name), a **non-clinical health/fitness facility** that provides a variety of exercise/fitness activities. To comply with pre-activity screening recommendations established by the American College of Sports Medicine, we have all participants complete a brief health history questionnaire. Based on the responses, your patient needs to obtain medical clearance prior to participating in our exercise/fitness programs. Once completed and signed by you, your patient can return this clearance form to me or you can fax it to me at _____ (secure fax number of fitness facility). If you have any questions, please feel free to contact me at _____. (phone number and e-mail address of exercise professional responsible for processing screening procedures).

Thank you,

_____

Name, credentials, and title of exercise professional staff member (e.g., John Smith, BS, ACSM EP-C, Fitness Director)

Please check (√) one of the following:

❑ Not cleared to exercise at this facility – should be referred to a clinically supervised exercise program

❑ Cleared to exercise at this facility

Please check (√) the highest exercise intensity level your patient is cleared for and provide any other restrictions/limitations

❑ Light (<57 to < 64% HR max)

❑ Moderate (64 to < 76% HR max)

❑ Vigorous (76 to < 96% HR max)

❑ Near Maximal to Maximal (> 96% HR max)

Restrictions/Limitations:

Physician's Name (printed): _____ **Physician's Signature:** _____

Phone number: _____ **Date:** _____

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