



P.O. Box 120099
West Melbourne, FL 32912
Phone 800 264 2562 Fax 321 308 7775

Medical Clearance for Exercise

(The physician's office staff may either mail this form, or fax it to 321-308-7775)

Participant name (Please print): _____ DOB: ____/____/____

Emergency contact: _____ Phone: _____

I give my physician permission to release to CCM Health Initiatives any medical information or files deemed relevant to my participation in an exercise program.

I understand that my participation in CCM Health Initiatives Programs requires a physician's approval before I can receive guidance for a progressive exercise routine. I agree to notify my health consultant of any medical changes while participating in the Restore program.

Note: Individual exercise programs are designed and monitored in keeping with any limitations noted by the physician, and take into consideration medical history, exercise history, fitness level, available resources/equipment, climate and goals. We encourage participants to sensibly work toward regular exercise/activity that will promote both health and level of function.

Areas of focus include:

- checkmarks: aerobic, muscle strength, muscle power, range of motion/flexibility, skilled movement (balance, coordination and agility)

Participant's signature: _____ / ____/____

- checkboxes: Patient should not engage in an exercise program at this time. Patient has my permission to engage in an exercise program without restriction... Patient has my permission to engage in an exercise program with the following precautions, restrictions, conditions or limitations...

See back of sheet
See attached sheet(s)

Physician Signature _____ Date ____/____/____

Physician name _____ Phone: _____ FAX: _____