Statement of Medical Clearance for Exercise

Participant's name: _____

Address: _____

Date of birth: _____

Email: _____

Physician's name: _____

Address: _____

Phone number: _____

Please indicate below, your medical recommendations for_____ use of Grace College's Gordon Health and Wellness Center facilities and equipment.

☐ YES my patient has no current unstable medical problems that are contraindicating to exercise

☐ NO my patient is not eligible to participate in physical exercise

Any special modifications, previous exercise program, or specific instructions?

_____

_____

_____

_____ _____

Physician's signature Date