



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