Medical Clearance Form

Dear Dr. ________________________________.

Your patient, ________________________________ wishes to participate in fitness testing and/or an exercise program at the Central Health Improvement Program (C.H.I.P.) facility in protocols designed for presumably healthy individuals.

The fitness testing program involves a submaximal cardiovascular protocol: step or treadmill/walking test; body composition will be analyzed by using the skinfold technique; flexibility will be assessed using sit and reach. A muscle strength and endurance test may also be performed per participant’s needs assessment and ability.

The general purpose of the testing is to establish a baseline from which a specific exercise program will be designed for the participant. The exercise programs are designed to place a gradually increasing workload on the cardiovascular system and the rest of the body to improve overall fitness.

All fitness tests and exercise programs will be administered by qualified personnel; certified and trained to conduct the tests, program design, and CPR. A specific program to achieve the safest and most effective results will be based upon the participant’s needs, interests, and goals, as well as your recommendations.

If you know of any medical, orthopedic, contraindication, or restriction for the participant wishing to participate in the Central Health Improvement Program fitness testing and/or exercise program, please indicate them on this form.

The participant requires physician clearance for the following reason(s):

☐ Has marked a box indicated MC on Pre-participation Screening Questionnaire
☐ Other: ______________________________________________________________

To be completed by Physician:

_____ I know of no reason why the participant may not participate.

_____ The participant is able to participate, but I urge caution for the following reason(s):

________________________________________________________________________

_____ The participant should not engage in the following exercises/activities:

________________________________________________________________________

_____ I recommend that the participant NOT participate.

_________________________                                ________________
Physician’s Signature                                 Date

Thank you for your assistance.

If you have any questions regarding this clearance request or the testing and programs at the C.H.I.P. facility please contact Mychael King, Coordinator/Fitness & Conditioning at (989) 774-3245.

PLEASE MAIL OR FAX THIS FORM TO: Central Health Improvement Program - CMU
Attn: Mychael King
Mount Pleasant, MI 48859
Fax (989) 774-2177