



Medical Clearance Form

Dear Primary Physician:

Your patient, _____, wishes to exercise with the University of Iowa, Division of Recreational Services, personal training program which requires your medical clearance 1) due to the "yes" response(s) on the Health History/Physical Activity Questionnaire and /or 2) the individual is over 40 years of age and has not been involved in an exercise program on a regular basis.

By completing this form you are not assuming responsibility for our administration of the fitness testing and/or exercise programs. If you know of any medical or other reasons why participation and/or exercise programs by the applicant would be unwise, please indicate so on this form.

If your patient is taking medications that will affect his or her heart rate response to exercise, please indicate the manner of the effect (raises, lowers or has no effect at all.

Type of medication: _____

Effect: _____

I know of no reason why the applicant may not participate.

I believe the applicant can participate, but I urge caution because

The applicant should not engage in the following activities

I recommend that the applicant NOT participate.

Physician signature _____ Date ____/____/____

Physician Name Printed _____

Address _____

Phone _____

If you have any questions regarding the assessment and/or exercise programs, please call 335-9291. Thank you for taking the time to fill out the medical clearance for your patient.