DiSepio Institute for Rural Health and Wellness

Physician's Statement and Clearance Form

At the DiSepio Institute for Rural Health and Wellness Fitness Center, your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine.

On the Medical History Questionnaire that you have just completed, you identified that you have one or more coronary and/or other medical risk factors that may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin exercising at the Fitness Center.

In order to expedite this process, please fax this form to the physician of your choice. If the doctor is aware of your medical history, he/she may be able to complete this form and fax it right back to us.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at the DiSepio Institute for Rural Health and Wellness Fitness Center. All information will be kept confidential.

Patient's signature________________________________ Date________________

Information requested for____

Reason for medical clearance____

Physician's name___________________________ Phone_____________________

Address____

Fax______________________________________

For Physician Use Only

Please check one of the following statements

_____ I concur with my patient's participation with no restrictions

_____ I concur with my patient's participation in an exercise program if he/she restricts activities to:

____

_____ I do not concur with my patient's participation in an exercise program (if checked, the individual will not be allowed to exercise at the Fitness Center)

Reason____

Physician's name (type or print)____

Physician's signature__________________________________ Date_______________________

Please return fax to: Health Promotion and Service Specialist Melinda Krimmel

Phone 814-472-2783 Fax 814-472-3905