Medical Clearance and Physician's Consent Form

Please complete and return to:
Sheri K. Mar, MS, CN, *Certified Nutritionist, ACE-certified Personal Trainer & Medical Exercise Specialist.*
PO Box 17468
Seattle, WA 98127-1168
Phone / FAX: 206-789-6440

Your patient, _____(DOB: _____), has advised me that he/she intends to participate a fitness training program. Upon review of this patient's assessment form and risk factors, I will require medical clearance prior to starting the program. An exercise program will be designed based on this assessment which will include, but not be limited to, resistance training and cardiovascular training. The sessions will last approximately 30-60 minutes, and will begin at a moderate, sub-maximal level.

Please be advised that my patient, _____, should be subject to the following restrictions in the fitness assessment and/or in his or her exercise program:

_____
_____
_____

In addition, under no circumstances should he or she do the following:

_____
_____

If patient is taking medications that will affect his or her exercise capacity or heart-rate response to exercise, please indicate the manner of the effect (raises or lowers exercise capacity or heart-rate response):

Type of medication(s)_____
Effect(s)_____

Other notes/comments:

_____
_____
_____

I have discussed the foregoing restrictions and limitations with my patient and, with these specific restrictions, he or she has my permission to participate in a fitness assessment and pursue an exercise program under your guidance.

_____ Date:_____
Sign name

_____ Phone number: _____
Print name