# Statement of Medical Clearance

Name of Participant: ______________________________ Date of Birth: ______________

Participant Address: ________________________________________________________

| Surgery Information |
| --- |
| Name of Physician: __________________________ Contact Phone: ________________<br>Name of Surgery: _________________________________________________________<br>Surgery Address: _________________________________________________________ |

☐ **YES**. My patient, ___________________________ has no current, unstable medical problems that should prevent them from participating in the below training program (please tick any applicable). I approve of and support their participation in the exercise program as indicated below. I have discussed the signs and symptoms that would make this exercise program unsafe (please specify below).

| ☐ Cardio Circuit | ☐ Stretch and Strength |
| --- | --- |
| Circuit is a form of body conditioning or resistance training targeting cardio, strength and endurance. Classes are held for one hour. Please note that this is not a rehabilitation class. | Stretch and Strength is a program for older women, based on gentle exercise and aims to improve or maintain strength, mobility, flexibility and balance. Classes are conducted as floor or chair based exercise and some standing activity. Classes are held for one hour. Please note that this is not a rehabilitation class. |
| ☐ **Pilates** | ☐ **Bootcamp** |
| Work on your balance and body awareness through guided floor exercises. Small apparatus' and fit balls may be used. This class is not a pre or post-natal Pilates class although if you are post-natal you must be 6 to 12 weeks post-partum. Classes are held for one hour. Please note that this is not a rehabilitation class. | Sessions involve intense cardio, strength training and agility. This class is suitable for intermediate to advance participants. Classes are held for one hour. Please note that this is not a rehabilitation class. |

☐ **NO**. My patient, ___________________ is not eligible to participate in the exercise due to their current medical status.

Diagnosis and symptoms (please indicate any recommendations or specific comments):

_________________________________________________________________________

_________________________________________________________________________

Physician's Signature: __________________________________ Date: _______________

**Please contact RNSH for more information**
**A: 104a Reynard Street, Coburg 3058**
**P: 03 9386 7128** **E: admin@rsnh.org.au**