



# Statement of Medical Clearance

Name of Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Participant Address: \_\_\_\_\_

Surgery Information	
Name of Physician: _____	Contact Phone: _____
Name of Surgery: _____	
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).

<input type="checkbox"/> <b>Cardio Circuit</b>	<input type="checkbox"/> <b>Stretch and Strength</b>
Circuit is a form of body conditioning and 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.
<input type="checkbox"/> <b>Pilates</b>	<input type="checkbox"/> <b>High Intensity Interval Training (HIIT)</b>
A light to intermediate mat work Pilates session. 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 various interval timers of high intensity, followed by a varied recovery time. Duration approximately 40 minutes. This program is not suitable for pregnant clients nor is this 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: \_\_\_\_\_