

Medical Clearance for Fitness Assessment and/or Exercise Program

Dear Doctor:

Your patient _____ wishes to take part in an exercise program and/or fitness assessment through the University of Alaska Anchorage, Department of Health, Physical Education & Recreation. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a maximal graded exercise test (GXT) or sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, and muscular strength and endurance. Assessments follow standard American College of Sports Medicine (ACSM) guidelines.

After completing a readiness questionnaire we want to ensure medical clearance by seeking your advice in setting limitations to their program if any is warranted. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize (Doctor or Clinic Name) _____ to release to the University of Alaska Anchorage, Department of Health, Physical Education & Recreation, the health information listed below concerning my ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

Client's signature:	Date
Received by (UAA representative):	

Physician's Recommendations

	I am not aware of any contraindications toward participation in a maximum exercise test (GXT).	
	I am not aware of any contraindications toward participation in a fitness program including a submax test.	
	I believe the applicant can participate, but urge caution because:	
	The applicant should not engage in the following activities:	
	I recommend the applicant not participate in the above fitness program.	
Physician's signature		Date
Physician's name (print)	Phone	Fax
Address	City	State & Zip

**Save completed form to your computer then email as an attachment to mchriss@uaa.alaska.edu.
 THANK YOU!**