Stevens Institute of Technology

Physician's Clearance Form

Please return this form to Jill Pyzik

Date: ___________

Patient's name:_______________________________ **Age**: ____________

Date of last physical examination: _________________________________

_________ This patient may participate fully in a physical activity program consisting of cardiovascular, strength, and flexibility training without limitation.

_________ This patient may participate in a physical activity program with the following limitations and/or recommendations:

____

____

Please include a brief description of any medical condition that might affect his/her physical activity program:

____

____

If this patient is on any medication that may affect the heart rate or the blood pressure response to exercise (elevating or suppressing), please indicate:

I consider the above individual to be:

________ normal ________ prone to coronary heart disease

________ other (explain) ________ cardiac patient

Please fill in the following information if available:

Result of last GXT _____________

Blood pressure _____________

Glucose _____________

Total serum cholesterol ______________

HDL-C ________ LDL-C ______________

Triglycerides _______________

Physician's Signature _______________________________ Date ________

Please note: This record must be stamped with a physician's official stamp or by accompanied by a typed letter on a physician's letterhead, documenting that a medical evaluation has been performed on the named client. THE PHYSICIAN'S CLEARANCE FORM WILL NOT BE ACCEPTED WITHOUT SUCH PROPER VERIFICATION.