# MEDICAL CLEARANCE FORM

## The Groton Center Fitness Center

163 W. Main Street Groton, MA 01450  978.448.1170

Patient's Name: _____

Address: _____

Email: _____

Phone: _____

The patient identified above is a patient of mine and has requested that I provide the following information so that he/she may obtain a membership and use the facilities and equipment of the Fitness Center. I understand that the Fitness Center is an unsupervised facility. Accordingly, I state the following:

1. Health History:

| | |
|---|---|
| ( ) Cardiac | ( ) Pulmonary |
| ( ) Diabetes | ( ) CVD |
| ( ) Arthritis | ( ) Hypertension |
| ( ) Orthopedic | ( ) Other |

Please explain checked items if necessary:

_____

_____

2. Medications:

_____

_____

_____

3. Please indicate any specific guidelines or limitations for this patient?

_____

_____

4. Approval: I approve this applicant for her/his use of the Groton Senior Center Fitness Center

PHYSICIAN'S SIGNATURE:_____

PRINTED NAME: _____

PHONE: _____DATE:_____