



Perfect Fit Personal Training Medical Clearance Form

Your patient, _____, has applied to participate in One to One fitness training with Perfect Fit Personal Training, which requires your medical clearance prior to participation. Clearance indicates that this patient has no contraindications for participation in the below described fitness tests and One to One fitness training.

The program will include any or all of the following:

1. Health history questionnaire and health screening
2. Resting measures (e.g., heart rate, % body fat)
3. Muscle strength/endurance assessments.
4. Cardio respiratory assessment
5. Flexibility assessment
6. Fitness program to ensure functional capacity

Does your patient's risk factor assessment warrant such a medical examination prior to exercise testing? Please circle one: YES or NO

My patient, _____, is physically able to participate in the above-described testing regimen (>60% max VO₂ max), and an individually instructed exercise (aerobic and resistance training) program. Please circle one: YES or NO

Printed Name : _____, M.D. Phone # _____

Signature _____, M.D.

Address:

Please list any restrictions, contraindications, and/or concerns (including medications).
Thank you for your cooperation.

Please give back completed medical clearance to patient:

I, _____, give Perfect Fit Personal Training permission to obtain above information from my physician.