medical clearance form

Date _____

Dear Doctor,

Your patient _____ wishes to participate in a personalized exercise program. The program will involve the following:

_____

_____

If your patient is taking medications that will affect his or her heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on heart rate response):

Type of medication _____

Effect _____

Please identify any **restrictions** or **recommendations** deemed appropriate for your patient in this exercise program:

_____

_____

Please complete and fax this form to me at (201) 444-4948 at your earliest convenience. Should you have any questions, I can be reached at (201) 739-6993 or e-mail: jasonmm1@verizon.net Thank you.

Sincerely,
Jason Mittelman

My patient _____ is approved to begin an exercise program with the restrictions or recommendations stated above.

Signed _____ Date _____ Phone _____