PHYSICIAN'S STATEMENT AND CLEARANCE FORM

At the **Robert R. Colbert Sr. Wellness Clinic**, your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine.

On the Health History Questionnaire you have completed, you identified that you have two or more coronary and/or other medical risk factors which may impair your ability to exercise safely and/or you are a male over the age of 45 or a female over the age of 55, or meet the age criteria identified by the American College of Sports Medicine. **For this reason, you need to have a physician complete and return this medical clearance form before you undergo a maximal graded exercise test and before you are able to exercise at the wellness clinic**. Exercise tests are supervised by Dr. Andrew Getzin, Sports Medicine
Physician – 274-3724.

We recognize that you are eager to start your fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience at the Robert R. Colbert Sr. Wellness Clinic to be as safe as possible.

In order to expedite this process, please send or fax this form directly to your physician and have him or her complete and return this form to the address below. Your physician may deem it necessary to schedule an office visit with them prior to completing this form.

I hereby give my physician permission to release any pertinent medical information from any medical record to the staff at the Robert R. Colbert Sr. Wellness Clinic. All information will be kept confidential.

Patient's Signature ____ Date _______________

Information Requested for ____

Reason for Medical Clearance ____

Physician's Name ______________________ Phone _______________ Fax _______________

Address ____

FOR PHYSICIAN USE ONLY

Please check on of the following statements:

- o I concur with my patient's participation with no restrictions.
- o I concur with my patient's participation in an exercise program if he/she restricts activities to:
- o I do not concur with my patient's participation in an exercise program
  (If checked, the individual will not be allowed to join the Robert R. Colbert Sr. Wellness Clinic)

Reason ____

Physician's Name ____

Physician's Signature ____ Date ______________

Please Return To:
Robert R. Colbert Sr. Wellness Clinic
302 Center for Health Sciences
Ithaca College
Ithaca, NY 14850
Telephone: (607) 274-1301
Fax: (607) 274-7070

Adapted from Fitcorp 1990