PHYSICIAN'S STATEMENT AND CLEARANCE FORM

At **Ithaca College**, 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. **For this reason, you need to have a physician complete and return this medical clearance form before you begin participating in structured exercise on the Ithaca College campus. The structured exercise activities may include, but are not limited to participation in Personal Training, Group Exercise Classes, a graded exercise test, and peer-led walks on campus.**

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 Ithaca College 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 Wellness Clinic or Fitness Center staff at Ithaca College. All information will be kept confidential.

Patient's Name (Please Print) _____

Patient's Signature _____ Date _____

Reason for Medical Clearance _____

Physician's Name _____ Phone _____ Fax _____

Address _____

FOR PHYSICIAN USE ONLY

Please check one 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 participate in the Ithaca College exercise portion of the program)

Reason _____

Physician's Name _____

Physician's Signature _____ Date _____

Please Return To:
Ithaca College Wellness Clinic
Attn: Exercise and Wellness Specialist
Ithaca College
Ithaca, NY 14850
Telephone: (607) 274-1301
Fax: (607) 274-7070