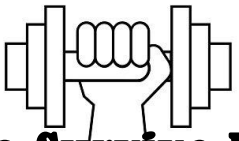

Power to Survive Program

Physician Statement and Clearance Form

Welcome to Power to Survive! You have been recommended to this program by your physician. Your physician will need to complete and return this medical release form before beginning this program at _____. Medical records will be requested only if your physician indicates that your activity is restricted. All medical information that is released will remain confidential and secure.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at_____. All information will be kept confidential.

Patient name:_____
Date of Birth:_____
Patient signature:_____
Today's Date:_____
Patient phone number:_____
Reason for Medical Clearance (Dx):_____
Physician's name:_____
Phone:_____
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 with the following restrictions:_____ _____
- o I do not concur with my patient's participation in an exercise program. (If checked, the patient will not be allowed to join program at above location) for the reason of: _____ _____

Physician Name: _____
Physician's signature:_____
Date:_____

*Please return to above fitness location to enroll and begin the Power to Survive Program