Albert Pujols
Wellness Center for *Adults* with
Down Syndrome

Medical Clearance Form

Name_____DOB_____

Height_____ Weight _____ BP_____/_____

Date of physical _____

I acknowledge that it is my responsibility to notify the Wellness Center staff of any changes to the client's medical or mental health status.

_____

Parent/Guardian Signature **Date**

Current Medical Concerns:

_____

_____

Additional/Past Medical History (including any cardiac history):

_____

_____

Is there a history of Atlanto-Axial instability? Yes No

Are you aware of any medical problems that are a contraindication for this patient to participate fully in a supervised exercise program? Programming may include, but is not limited to: yoga, Tai Chi, Zumba, circuit exercises, and light strength training

Patient is cleared to participate in full exercise programs?
Yes No

In your medical opinion, is the patient able to participate in exercise classes without restrictions?
Yes No

Please list any restrictions:

_____

_____

Physician's signature required to participate in ADS classes and programs **DATE**

Physician's printed name Phone number

Revised January 2026