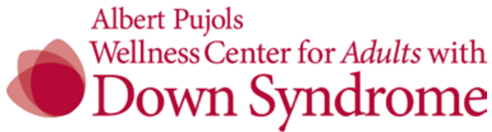

Medical Clearance Form

Name_____________________________________ DOB_____________ Age__________

Height___________ Weight __________ BMI ___________ BP_________/__________

Date of last physical exam____

Past Medical History or Current Concerns______________________________________
____
____
____

Is there A/O instability? Yes No

Please list any behavioral concerns we need to be aware of for this individual?
____
____
____

Are there any social or emotional concerns that we need to be aware of?
____
____
____

Please list any dietary restrictions or food allergies?
____
____
____

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

Please list any restrictions:
____
____
____

Other concerns not previously listed:
____
____
____

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