Ramsay Court, MILDURA. Vic.
Phone: (03) 5022 5444 Fax: (03) 5022 5445
POSTAL ADDRESS: P.O. BOX 2803, MILDURA 3500

Reference No: HP 015 HO

PHYSICAL ACTIVITY
REQUEST FOR MEDICAL CLEARANCE

(Please print all details)

Participant to complete:

Surname: ______________________ Today's date: ___/___/___

Given Name: ______________________ Date of Birth: ___/___/___

Address ________________________________ P/C: ______________

Contact Phone: ______________________ Gender: ☐ Male ☐ Female

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Surname: ______________________ Given Name: ______________________

Contact Phone: Relationship:

Medical Practitioner to complete:

MEDICAL HISTORY

Has your patient ever required medical attention for any of the following (please tick or write in space provided)

		Year of Onset (Approx)				Year of Onset (Approx)
Diabetes	☐	________		Respiratory Disease	☐	________
Renal disease	☐	________		Osteoporosis	☐	________
High blood pressure	☐	________		Skin conditions	☐	________
Cardiac condition	☐	________		Epilepsy	☐	________
Stroke	☐	________	*Residual effect/s*:	________________		
Arthritis	☐	________	*Site/s*:	________________		
Cancer	☐	________	*Type*:	________________		
Joint replacement	☐	________	*Site/s*:	________________		
Cognitive disorder	☐	________	*Type*:	________________		
Uncorrected visual problem	☐	________	*Type*:	________________		
Mental Health Condition	☐	________	*Describe*:	________________		

Other Medical History (not outlined above) ________________________________

Please list any movements to be avoided: ________________________________

Medication

Name	Dosage	Frequency	Name	Dosage	Frequency

Please list any medications which should be available during exercise: ______________________

I consider my client can safely participate in the following physical activity programs. ☐ No ☐ Yes

I consider a progressive physical activity program is necessary to aid in the treatment of: ______________________

☐ Warm water exercises ☐ Make a Move (Falls prevention and nutrition) ☐ Movers & Groovers (chair based)

☐ Hearts a go-go (low-moderate intensity) ☐ Parkinsons Disease (low-moderate) ☐ Walking

Doctor's Signature: ______________________ **Date**: ______________

Name: ______________________ **Provider No**: ______________

Address: **Phone No**: