



**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	<input type="checkbox"/> _____	Respiratory Disease	<input type="checkbox"/> _____
Renal disease	<input type="checkbox"/> _____	Osteoporosis	<input type="checkbox"/> _____
High blood pressure	<input type="checkbox"/> _____	Skin conditions	<input type="checkbox"/> _____
Cardiac condition	<input type="checkbox"/> _____	Epilepsy	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/> _____	<i>Residual effect/s:</i>	_____
Arthritis	<input type="checkbox"/> _____	<i>Site/s:</i>	_____
Cancer	<input type="checkbox"/> _____	<i>Type:</i>	_____
Joint replacement	<input type="checkbox"/> _____	<i>Site/s:</i>	_____
Cognitive disorder	<input type="checkbox"/> _____	<i>Type:</i>	_____
Uncorrected visual problem	<input type="checkbox"/> _____	<i>Type:</i>	_____
Mental Health Condition	<input type="checkbox"/> _____	<i>Describe:</i>	_____
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  Low intensity exercise (strength and balance)  Walking group

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Provider No: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone No: \_\_\_\_\_