MEDICAL CLEARANCE

Participant's Name:_____

Date:_____

Address:

_____

DOB:_____ Phone:_____

Dear Doctor: _____

We need your permission for _____ to participate in a Senior Fitness Program to be held at the East Providence Senior Center. Our program includes the use of 6 dual hoist fitness machines, cardiovascular equipment (i.e.: recumbent bike, treadmill and elliptical trainer), hand weights, ankle cuff weights and TheraBand for strength training as appropriate. An individualized orientation is given to each participant. This program's grant funding has ended, so the patient will pay a small yearly fee and the City of East Providence will subsidize the rest of the program's cost.

Pertinent Medical History:

_____

_____

_____

_____

Any Special Considerations or Precautions to Exercise:

_____

_____

_____

_____

The above listed person is capable of participating in a senior fitness program established by a licensed physical therapist, but without one-on-one supervision.

Signed:_____M.D. Date: _____

Name of Physician:_____

Address:_____

Phone:_____