PERSONAL TRAINING

MEDICAL CLEARANCE

FORM

Dear Doctor:

__________________________________ wishes to start a personalized training program at

name of applicant

the University of Washington, Department of Recreational Sports Programs. The Personal Training package includes an exercise screening (body composition analysis, blood pressure and resting heart rate checks, and height and weight measurements), consultation, and on-the-floor training. The exercise program is designed to start easy and become progressively more difficult over a period of time. Both resistance and cardiovascular training exercises will be part of the client’s program. All exercise screening and exercise programs will be administered by personal trainers trained in conducting exercise screenings and developing exercise programs.

By completing the form below, however, you are not assuming any responsibility for our administration of the exercise screening and/or exercise programs. If you know of any medical or other reasons why participation in the exercise screening and/or exercise programs by the applicant would be unwise, please indicate so on this form.

If you have any questions about the University of Washington exercise screening procedures and/or exercise programs, please call the Fitness Coordinator at 206-616-2072. Please call our offices at 206-543-2571 if you plan on faxing the completed form to us (Fax: 206-685-4661).

Report of Physician

_____ I know of no reason why the applicant may not participate.

_____ I believe the applicant can participate, but I urge caution because _______________________

________________________________________________________________________

________________________________________________________________________

_____ The applicant should not engage in following activities: ___________________________

________________________________________________________________________

________________________________________________________________________

_____ I recommend the applicant NOT participate.

Physician’s signature ___________________________ Date ________________________