



Medical Clearance

1121 Forrest Ave. Dover, Delaware 19904 302-734-1200 FAX 302-674-1265

Dear Doctor:

Your patient _____ has applied to participate in an exercise program at the Modern Maturity Center, Inc. Wellness Center. Our program requires that this patient have a medical clearance before participating in the fitness program. Your patient will be exercising between 60%-85% of an age predicted maximum heart rate. A body fat measurement and a flexibility assessment will be used to develop the exercise program.

All exercise programs will consist of aerobic type exercises performed in aerobic classes and on treadmills, bikes and elliptical machines. A progressive flexibility and resistance program will be included, if there are no contraindications to the exercises.

The Modern Maturity Center, Inc. asks if you will determine whether the above named individual is medically fit to participate in an exercise program. Should you have any questions regarding any of our programs, please give us a call at 734-1200, ext 187.

Sincerely,

Modern Maturity Center

- A. I have medically evaluated this patient and find he/she is medically fit to participate in the aforementioned exercise program.

Contraindications _____

Comments: _____

Physician's Signature _____ Date _____

- B. I find it medically contraindicated for this patient to enter the aforementioned fitness program.

Comments _____

Physician's Signature _____ Date _____

Please Print Clients Name _____ Contact Number _____ Date Called _____ Date of Assessment _____
