LiveWell
HEALTH & FITNESS PROGRAM

STATEMENT OF MEDICAL CLEARANCE FOR EXERCISE

This page to be completed by Doctor *Please attach further pages if more detail is required.*

Date/results of latest Bone Density Test (if applicable):_____

Current BP: _____ **Heart Rate:** _____ **Cholesterol level:** _____

Current Medications: _____

_____

_____

Will these medications have any effect on physical activity? _____

_____

If any of the following apply, please tick, comment and add specific precautions.

- ☐ Osteoporosis_____
- ☐ Orthopaedic _____
- ☐ Previous Surgery _____
- ☐ Arthritic R/A or O/A _____
- ☐ Specific spinal limitations_____
- ☐ Muscular skeletal injuries _____
- ☐ Cardiac/circulatory_____
- ☐ Asthma/respiratory disorders _____
- ☐ Cancer _____
- ☐ Neurological _____
- ☐ Epilepsy _____
- ☐ Cerebellar problem (ataxia) _____
- ☐ Visual/depth preception prob. _____
- ☐ Chemical dependency_____
- ☐ History of falls _____
- ☐ Diabetes _____
- ☐ Polio/post polio syndrome _____
- ☐ Pathology undergoing further testing_____

☐ **YES** my patient may participate in the LiveWell program

☐ **NO** my patient is not eligible to participate in this program due to his/her current medical status

☐ I would like to discuss the LiveWell program with you, please call me

Physician Details (stamp):

Physician Signature: _____ **Date:** _____

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CLIENT HEALTH INFORMATION

This page to be completed by Client/Patient

Name: _____

Address: _____ Post code: _____

Home Telephone number: _____ Mobile: _____

Date of Birth: _____ Age: _____

Please provide details of your paramedical professional:

(eg: osteopath, physiotherapist, chiropractor,myotherapist or masseur)

Name: _____

Business address: _____

Telephone number: _____ Email: _____

Please provide details of any specialist you are seeing:

Name: _____

Business address: _____

Telephone number: _____ Email: _____

Emergency contact details (please provide details for two contacts):

CONTACT 1

Name: _____

Relationship to you: _____

Home/Business Telephone: _____

Mobile: _____

CONTACT 2

Name: _____

Relationship to you: _____

Home/Business Telephone: _____

Mobile: _____

HEALTH STIPULATION

Should your physical/medical condition adversely change, the following will be required by your LiveWell Instructor:

- Notification in writing of the change to your condition
- A written clearance from your medical practitioner or health professional to continue exercising

I certify that the information on this form is accurate and that if my condition changes at any time, I will immediately advise my LiveWell Instructor or another staff member at my Swim, Sport and Leisure centre.

Client signature: _____ **Date:** _____