Physician Clearance Form

Please return form to: St. Louis City Fitness**,** L.L.C.
Address: 7335 Richmond Place, St. Louis, Missouri 63143
Phone: (314) 276-6694**, Fax:** (314) 781-2590

Patient's name: _____ Date of Birth: _____ Age: _____

Date of last physical examination: _____

Please check the appropriate box:

☐ This patient, _____, may participate fully in a physical activity program consisting of cardiovascular, strength, and flexibility training *without limitation*.

☐ This patient, _____, may participate fully in a physical activity program consisting of cardiovascular, strength, and flexibility training *with the following limitations or recommendations:*

Please include a brief description of any medical condition that might affect his/her physical performance:

If the patient is on any medication that may affect heart rate or blood pressure response to exercise (elevating or suppressing), please indicate:

I consider the above individual to be:

- ☐ Normal
- ☐ Cardiac patient
- ☐ Prone to cardiac heart disease
- ☐ Other (please explain) _____

Please fill in the following information if available:
Result of last GXT _____
Blood pressure _____
Glucose (fasting) _____
Total Serum cholesterol _____/ HDL-C _____/ LDL-C _____Triglycerides _____

Physician’s signature _____ Date _____