



THE SCOTT CENTERTM

for clinical and exercise psychology

MEDICAL CLEARANCE FORM

Dear Doctor:

Your patient, _____, is enrolling in our treatment program which involves prescribed exercise intervention as an adjunct treatment to our behavioral health services.

The patient's exercise prescription will be defined and monitored by qualified personnel trained in conducting exercise programs (exercise physiologists, certified personal trainers). If you know of any medical, or other reasons why participation in this program would be unwise, please indicate so on this form. By completing the form below you are not assuming any responsibility for your administration of the exercise program.

REPORT OF PHYSICIAN

Please initial one of the following:

_____ I know of no reason why the patient may not participate

_____ I believe the patient can participate but I urge caution because:

(Please list limitations)

_____ The patient should not engage in the following activities:

_____ I recommend the patient not participate

(continued on back)

Physician Signature: _____ Date: _____

Address: _____ Phone: _____

City and State: _____ Zip: _____

MEDICAL RECORDS RELEASE AUTHORIZATION

I give permission to release any medical information that may be beneficial for preparing an exercise prescription and behavioral health exercise intervention to The Scott Center.

Patient Signature: _____ Date: _____

Patient Name: _____