



**Medical Clearance Form**

Date \_\_\_\_\_

Dear Doctor:

Your Patient, \_\_\_\_\_ wishes to exercise. The activity will involve the following: aerobic, strength, balance, flexibility, and other physical activity training. If your patient is taking medications which will affect his or her heart rate response to physical activity, please indicate the manner of the affect (raises, lowers, or has not affect on heart rate response).

Type of Medication \_\_\_\_\_ Affect \_\_\_\_\_  
Please identify any recommendations or restrictions that are appropriate for your patient in this program:

\_\_\_\_\_  
\_\_\_\_\_

Thank you.

Sincerely,

Leilani Cronin, Ph.D.  
Empowered Health, LLC

\_\_\_\_\_ has my approval to participate in the physical activity of this program with the recommendations or restrictions stated above.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Please read the following and sign Waiver and Assumption

In consideration of the acceptance of participation in this program, I, for myself, my heirs, executors, administrators and assigns, waive, release and discharge any and all rights and claims for damages against Empowered Health, LLC, and the directors, and agents of the company, for all claims arising or resulting from participation in physical activity. I attest and verify that I have full knowledge of the risks involved in these activities and I will assume those risks for the person above.

Signed \_\_\_\_\_ Date \_\_\_\_\_