MOVEMENT REVOLUTION

Medical Clearance Form for Exercise

To be completed by Primary Care Physician or Neurologist

Patient Name: _____ Date: _____

Date of Birth: _____/_____/_____ Height: _____ Weight:_____ Resting Pulse:_____ Blood Pressure:____/_____

Diagnosis:

_____ Amputation Cause: _____ Level: _____
_____ Arthritis Areas: _____
_____ Cancer Type: _____
_____ Cerebral Palsy
_____ Head Injury Cause: _____
_____ Multiple Sclerosis
_____ Parkinson's disease Symptoms:_____
_____ Stroke Hemiparesis: _____ Aphasia:_____
_____ Spinal Cord Injury Cause: _____ Level _____ Complete Incomplete
_____ Visual Impairment
_____ Other: (Explain disability & cause) _____

Date of Onset or Diagnosis: Congenital (*present at birth*) OR Acquired or diagnosed on this date: ___/___/___

Dates of hospitalization in past two years with admitting diagnosis: _____

_____

Medications (please attach list if appropriate) _____

Allergies: _____

Please indicate if applicable:

Seizures YES NO How many in the past 12 months: _____ Date of most recent seizure: ___/___/___

Diabetes	YES	NO	Use Insulin	YES	NO
Heart Disease	YES	NO	High Blood Pressure	YES	NO
Asthma	YES	NO	Heat Related Problems	YES	NO

Other: _____

Comments/Restrictions:_____

_____

Physician Name: (Print) _____**Phone:** _____

Email Address: _____ Nurse: _____

Hospital: _____

APPROVAL FOR PARTICIPATION: YES NO

Physician's Signature: _____ Date: _____/_____/_____

Mail/Fax/Email completed form to:
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