KALEV
FITNESS
SOLUTION

MEDICAL CLEARANCE FORM

Date: _____

Dear doctor:

Your patient, _____ has applied to participate in a comprehensive fitness assessment and one –on-one, group, or class training with Kalev Fitness Solution Inc., which requires you medical clearance prior to participation. Clearance indicates that this patient has no contraindications for participating in the below described fitness test and one-on-one training. The patient will have one or all of the following tests administered to determine his/her state of fitness.

1) Health risk appraisal/questionnaire
2) Resting measures (i.e. heart rate, blood pressure, body composition)
3) Cardio respiratory assessment (e.g. sub maximal bicycle ergo meter test)
4) Muscular strength/endurance assessment and conditioning
5) Flexibility assessment and conditioning
6) Postural assessment

Please identify any recommendations or restrictions that may be appropriate for your patient in this exercise program including medications that may affect his/her heart rate response to exercise.

_____

_____

_____

My patient,_____, has my approval to participate in the above described testing and exercise regimen with the recommendations or restrictions stated above.

Signed: _____ Date:_____

Name (print):_____

Thank you for your co-operation.

Any Questions or Concerns please call or email:

Kalev Fitness Solution Inc.
(604) 568 - 6006
Kalev@KalevFitness.com