

N O R T H A M P T O N  
*Senior Services*



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Director: Marie Westburg  
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## Medical Clearance for Exercise

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Printed name: \_\_\_\_\_ Tel.: \_\_\_\_\_

Address: \_\_\_\_\_

The above named individual would like to participate in an exercise program. The program may consist of strength training with light hand weights, light cardio- respiratory conditioning, specific exercises for the improvement of balance and will be implemented in a positive and supportive group setting.

The program will be led by instructor(s) with knowledge of safe and effective exercise for people ages 60+ who currently hold certification from a nationally recognized certifying exercise organization.

The participant is required to complete a medical history and health survey prior to participation in this exercise program.

**Yes** My patient, \_\_\_\_\_, has no current unstable medical issues that may contraindicate participation in this exercise program.

**No** My patient, \_\_\_\_\_, is not eligible to participate in this exercise program due to their current medical status.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Tel.: \_\_\_\_\_

Address \_\_\_\_\_