



Valley Medical Fitness Center

Medical Clearance Request Form

To Be Completed by the Physician

Physician: _____

Date: _____

Fax No: _____ Phone
No: _____

Patient's Name: _____

Birth

Date: _____

Daytime Phone: _____

Your patient has requested to participate/return to participation in the following program(s) at Valley Fitness Club:

<input type="checkbox"/> Supervised Water Exercise	<input type="checkbox"/> Unsupervised Exercise
<input type="checkbox"/> Supervised Exercise	<input type="checkbox"/> Mind/Body Classes (Yoga, Tai Chi, Qi Gong, Pilates, etc.)

Due to their medical history it is necessary that we request a medical clearance. Contraindications for membership are as follows:

- Unstable orthopedic condition .. ➤ Uncontrolled diabetes
- Coronary, Pulmonary, or Metabolic conditions including, but not limited to:

Symptomatic arrhythmias
Hypertrophic cardiomyopathy

Recent embolism

Symptomatic aortic stenosis
hypertension

Resting BP over 180/110

Pulmonary

Unstable angina
Symptomatic congestive heart failure

Active thrombophlebitis

Medical Screening Questions:

1. Has the patient had an MI, CABG, angina, angioplasty, atherectomy, or symptoms of coronary artery disease?

Yes _____ No _____ Date: _____

If Yes, please explain: _____

2. Has the patient had a history of Pulmonary, Metabolic, or Vascular Disease?

Yes _____ No _____ Date: _____

If Yes, please explain: _____

If yes to either question 1 or 2, a treadmill stress test done within the last 12 months is required prior to enrollment at the Fitness Center. Please send a copy of recent treadmill results.

_____ Treadmill waived. I do not wish to perform a maximum treadmill test on this patient although he/she falls within the American College of Sports Medicine guidelines for testing prior to exercise.

Date of last treadmill: _____ (Please attach a copy)

Any Abnormalities? _____

3. Has the patient recently undergone any surgery? Yes _____ No _____ Date: _____

If Yes, please explain: _____

4. Does the patient have any other medical conditions which may limit exercise? Yes _____ No _____

If Yes, please explain: _____

Exercise Recommendations:

_____ No Restrictions

_____ Restricted from the following activities:

_____ Treadmill	_____ Weight training	_____ Steam room
_____ Stairmaster	_____ Gym aerobics	_____ Swimming

_____ Bike _____ Water aerobics _____ Other: _____
_____ Rowing machine _____ Recreational sports

Physician Signature: _____
Date: _____

(Please return to Valley Fitness Center at 400 S. 43rd St., PO Box 50010, Renton, WA 98058 or Fax to 425-656-5356)