FIT MONKEYS

MEDICAL CLEARANCE FOR EXERCISE

Dear Physician / Healthcare Provider,

Your patient has expressed interest in beginning or continuing an individualized exercise program with **Fit Monkeys**.

Depending on the client's goals, abilities, health history, and individual program, exercise sessions may include:

- Cardiovascular exercise
- Resistance and strength training
- Pilates and Pilates apparatus exercises
- Functional movement exercises
- Balance and stability training
- Mobility exercises
- Flexibility and stretching
- Core strengthening and stabilization
- Bodyweight exercises
- Low-impact conditioning
- Other appropriate personal training exercises

Exercise intensity, exercise selection, resistance, range of motion, and progression are individualized and may be modified based on the client's abilities, limitations, goals, and response to exercise.

Fit Monkeys provides **fitness instruction and exercise programming and does not provide medical diagnosis, treatment, rehabilitation, or physical therapy.**

We are requesting your guidance regarding whether your patient may safely participate in an exercise program and whether there are any precautions, restrictions, or other considerations we should be aware of.

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

MEDICAL CLEARANCE

Please select the option that best applies:

☐ **I hereby give this patient medical clearance to participate in an exercise program without specific restrictions.**

☐ **I give this patient medical clearance to participate in an exercise program with the precautions and/or restrictions listed below.**

☐ **I do not recommend that this patient participate in an exercise program at this time.**

☐ **Additional evaluation or treatment is recommended before this patient begins or resumes an exercise program.**

PRECAUTIONS / RESTRICTIONS

Please indicate any exercises, movements, positions, intensity levels, ranges of motion, or other activities that should be avoided or modified:

RELEVANT MEDICAL CONSIDERATIONS

Please list any medical conditions, recent procedures or surgeries, orthopedic considerations, cardiovascular considerations, or other information relevant to safe exercise participation:

MEDICATION CONSIDERATIONS

Is the patient currently taking any medications that may affect their response to exercise, including medications that may influence **heart rate, blood pressure, balance, coordination, blood glucose, hydration, fatigue, or exercise tolerance**?

☐ No

☐ Yes — please explain any exercise-related considerations:

Examples may include medications that alter the normal heart-rate response to exercise or otherwise affect how exercise intensity should be monitored.

ADDITIONAL RECOMMENDATIONS

Please provide any additional recommendations that may help us safely individualize this patient's exercise program:

HEALTHCARE PROVIDER AUTHORIZATION

Based on my knowledge of this patient's current medical status and the information provided above, I have indicated my recommendation regarding participation in an individualized exercise program.

Healthcare Provider Name: _____

Practice / Facility: _____

Phone: _____

Signature: _____

Date: _____