



**CENTRAL CLEMSON RECREATION CENTER
Physician Consent Form**

Patient's Name: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Cell: _____

Physician: _____

Physician's Phone: _____

Email or Fax: _____

According to a medical history interview and/or physical examination conducted on: Month: _____

Day: _____ Year: _____, I have found the above patient ___ **eligible** or _____ not eligible for participation in unmonitored fitness programs. This may include fitness testing, fitness classes, or use of exercise equipment. Medical Conditions or Medications: _____

Physical Limitations: _____

Recommendations for Exercise: _____

Signature of Physician: _____ Date: _____