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: _____

Please email or document to the following: ecade@cityofclemson.org