

Physician's Medical Clearance

SOUTH BRUNSWICK OFFICE ON AGING/SENIOR CENTER

540 Ridge Rd, Monmouth Jct, NJ 08852, Phone 732 329-4000 x7670 Fax 732 438 9826

Having reviewed the medical history of _____

Print Participant's Name

And having examined the above-named individual in regard to their desired participation in the following exercise/fitness program sponsored by the South Brunswick Office on Aging/Senior Center:

Please check whichever would be appropriate for your patient:

- | | |
|--|--|
| <input type="checkbox"/> Senior Adult Fitness Program (Beginner) | <input type="checkbox"/> Senior Adult Fitness (Intermediate) |
| <input type="checkbox"/> Senior Adult Fitness (Advanced) | <input type="checkbox"/> Pilates |
| <input type="checkbox"/> Yoga | <input type="checkbox"/> Balance Strength Training |
| <input type="checkbox"/> Tai Chi | <input type="checkbox"/> Dance |
| <input type="checkbox"/> Floor Exercises | <input type="checkbox"/> Gym-Treadmills, bikes etc. |
| <input type="checkbox"/> Chair Exercises | <input type="checkbox"/> Arm Machine Exercises |
| <input type="checkbox"/> Virtual Classes | <input type="checkbox"/> Now & Zen |

BASED UPON MY REVIEW: *Please check one:*

- Participation in any and all fitness programs approved without limitations.
- Participation not approved for fitness programs.
- I recommend the following limitations for their participation:

Please PRINT any information about this patient that the instructor should be aware of:

Physician's Name (Please type or print)

Address

Zip

Phone

Physician's Signature

Date

Physician's stamp