ReYu Paralysis Recovery Centre

MEDICAL PHYSICIAN CLEARANCE FORM

NAME OF CLIENT	SURNAME	GIVEN NAMES	INITIAL
ADDRESS OF CLIENT			

CITY	PROVINCE	POSTAL CODE	DATE OF BIRTH YYYY	M M	D D

Dear Doctor

Your patient has an interest in taking part in an Activity Based Training program and/or TheraSuit program through ReYu Paralysis Recovery Centre. As a prerequisite, the Client must get clearance and confirmation that they are safe to begin an exercise based program.

To minimize the health risk, we are requesting this clearance form to determine whether the client is healthy enough to undertake either the Activity Based Training or TheraSuit Program.

Current diagnosis:_____

Any concerns, contraindications to physical exercise or pending diagnoses?

_____

_____

_____

_____

_____

Based upon my review of the health status I recommend, that the above named individual have:

- ☐ Full, unrestricted participation in the programs
- ☐ Limited participation in the programs with avoidance of:_____
- ☐ Limited participation until further medical clearance due to:_____
- ☐ No participation; Not a candidate

Examining Physician's Office Stamp:

_____
Physician signature

_____
Date