

Provider _____

Your patient, _____, DOB _____ has enrolled in the InSHAPE program, which provides access to fitness facilities and a personal trainer. Your patient will be engaging in aerobic, strength, and flexibility exercise. Medical clearance is required for participation. Please answer the following questions

Does your patient have any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Coronary heart disease or heart attack | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> Uncontrolled High blood pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | |

Please address the limitations associated with any of the conditions checked above including any other known conditions that would affect this patient in regards to physical activity.

- Participant has no limitations
- Participant is medically cleared to participate in the In SHAPE program with the above mentioned limitations
- Participant is NOT medically cleared to participate in the In SHAPE program

Additional comments:

Provider signature

Date