



# CAPE REGIONAL MIRACLES FITNESS

A member of Cape Regional Health System

## Medical Clearance Form

Dear Dr. \_\_\_\_\_:

Your patient is interested in beginning an exercise program at Cape Regional Miracles Fitness. Each individual exercise program is designed to gradually improve and maintain cardio-respiratory fitness, muscular strength and endurance, flexibility and healthy body composition.

The cardio-respiratory prescription includes a warm-up, exercise at appropriate target heart rate and/or perceived exertion for a predetermined duration, and cool down. The muscular strength and endurance prescription involve progressive resistance exercise performed at an appropriate rating of perceived exertion. Keiser air pressurized machines and/or free weights and body weight exercises are used for a; resistance exercises. The flexibility prescription involves performing stretching exercises for the major muscle groups using static stretching or proprioceptive neuromuscular facilitation (PNF) techniques. The rate of progression for each exercise prescription is regulated through monthly evaluations.

Each participant is required to receive a Physician's clearance prior to beginning the exercise program. By completing this form, you are not assuming any responsibility for our administration of the exercise program. If you know of any reason why participation in the exercise program is unwise, please indicate so on this form and return to:

**Cape Regional Miracles Fitness**  
**408 Rio Grande Avenue, Rio Grande, NJ 08242**  
**P: (609)886.7070 F: (609)886.7085**

### Report of the Physician

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ The client may participate in the fitness testing/exercise program without restriction.

\_\_\_\_\_ The client may participate in the fitness testing/exercise program with the following restrictions:

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\_\_\_\_\_The client may NOT participate in the fitness testing/exercise program at this time:

Physician's Name: (please print) \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physicians Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Staff Notes: \_\_\_\_\_

Appointment Date: \_\_\_\_\_