



# The University of Akron

## PHYSICIAN'S STATEMENT AND CLEARANCE FORM

The University of Akron

At the Student Recreation and Wellness Center (SRWC), your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine. On the Physical Activity Readiness Questionnaire (PAR-Q) or health screening you completed, you identified that you have one or more coronary and/or other medical risk factors which may impair your ability to exercise safely. For this reason, you need to have your physician complete and return this medical clearance form before you can participate in our programs.

We recognize that you are eager to start your fitness program and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your experience at the SRWC to be as safe as possible. If your doctor is aware of your medical history, he or she may complete the form and fax it right back to us. In many cases, the delay is only one day.

***I hereby give my physician permission to release any pertinent medical information from any medical records to the fitness staff at the University of Akron Student Recreation and Wellness Center. All information will be kept confidential.***

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Information requested for: \_\_\_\_\_ (please clearly print your name)

Reason for requesting medical clearance:

\_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: \_\_\_\_\_

Address:

### FOR PHYSICIAN'S USE ONLY

Please check one of the following statements:

I concur with my patient's participation in an exercise program with no restrictions.

I concur with my patient's participation in an exercise program if he or she restricts activity to:

\_\_\_\_\_

I do not concur with my patient's participation in an exercise program.

(If this item is checked your patient will not be allowed to participate)

Reason: \_\_\_\_\_

Physician's name (type or print): \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form directly to: Manager of Fitness and Wellness

Fax # (330) 972-6715

**Student Recreation and Wellness Services**

382 Carroll Street, Akron, Ohio 44325