



DEPARTMENT OF EXERCISE & SPORT STUDIES
MEDICAL CLEARANCE

Please print CLEARLY:

NAME _____

HOME
ADDRESS _____

CAMPUS
ADDRESS _____

HOME & CAMPUS
PHONES _____

We're glad you have decided to join our exercise program. Please take a minute to answer the following questions, and return this form to your instructor or the ESS Office as soon as possible.

____ Yes ____ NO Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by a doctor?

____ Yes ____ NO Do you feel pain in your chest when you do physical activity?

____ Yes ____ NO In the past month have you had chest pain when you were not doing physical activity?

____ Yes ____ NO Do you lose your balance because of dizziness or do you ever lose consciousness?

____ Yes ____ NO Do you have a bone or joint problem that could be made worse by a change in Your physical activity?

____ Yes ____ NO Is your doctor currently prescribing drugs (ie. Water pills) for your blood pressure or heart condition?

____ Yes ____ NO Do you know of any other reason why you should not do physical activity? If yes, please explain.

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, you need to obtain your physician's written approval

Waiver of Liability:

By signing this document, I acknowledge that I am in good health or have obtained my physician's written approval to participate in this exercise program. I understand these classes may be strenuous, and choose to participate completely voluntarily. I accept all responsibility for my health and any resultant injury or mishap that may affect my wellbeing or health in any way. I hold harmless of any responsibility the instructor, facility or any person involved in this program.

Signature

Date

PHYSICIAN'S CLEARANCE FORM



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To the Physician:

Smith College offers an exercise program for Smith Employees and their families. Activities include aerobics, yoga, Pilates, tai chi and physical conditioning exercises (calisthenics and stretching). Please describe any limitations you would place on your patient's participation in the exercise program:

_____ I recommend participation in the exercise program.

_____ I do not recommend participation in the exercise program.

Signature

Date

Name and address of physician (please print):

