Medical Clearance Form

Patient Information

Name:	
Date of Birth:	
Gender:	
Address:	
Phone Number:	
Email:	

Emergency Contact

Emergency Contact Name:	
Relationship to Patient:	
Phone Number:	

Medical History

Primary Care Physician:	
Reason for Medical Clearance:	

Medical Conditions

List of Current Medications:	
Allergies:	
Chronic Illnesses/Conditions:	

Vaccination History

COVID-19 Vaccination Status:	
Other Vaccinations:	

Recent Tests and Screenings

Date of Last Physical Examination:	
Blood Pressure:	
Cholesterol Levels:	
Blood Sugar Levels:	
Other Relevant Test Results:	

Fitness and Activity Level

Physical Activity Level:	
Type of Exercise:	

Lifestyle Factors

Smoking Status:	
Alcohol Consumption:	
Dietary Restrictions/Preferences:	

Additional Notes/Comments:

Consent and Authorization:

I, the undersigned, hereby authorize the release of the information provided above to the relevant healthcare professionals for the purpose of medical clearance. I understand that this information will be used to assess my fitness for _____.

Patient's Signature: _____ Date: _____

Physician's Approval:

I hereby confirm that I have reviewed the patient’s medical history and provide clearance.

Physician's Name (Print):

Signature: _____ Date: _____