SAM POMERANZ
JEWISH COMMUNITY CENTER
OF SYRACUSE

A place where everyone belongs.

5655 Thompson Road
DeWitt, New York 13214
315.445.2360 | Fax: 315.449.4539
www.jccsyr.org

PHYSICIAN'S CLEARANCE FORM

Please return this form to: Laurie Kushner
JCC Sports & Fitness Center
5655 Thompson Rd., DeWitt, NY 13214
Fax: 315-449-4539 Phone: 315-234-4522

Patient's name: _____ Age: _____

Address: _____

Phone: _____

Date of last physical examination: _____

_____ This patient may / may not (circle one) participate fully in a physical activity program consisting of cardiovascular, strength and flexibility training without limitation.

_____ This patient may participate in a physical activity program with the following limitations and/or recommendations: _____

_____

_____

Please include a brief description of any medical condition that might affect his/her physical activity program: _____

_____

If this patient is on any medication that may affect the heart rate or the blood pressure response to exercise (elevating or suppressing), please indicate: _____

I consider the above individual to be:
____ Normal
____ Cardiac patient
____ Prone to coronary heart disease
____ Other (explain): _____

Please fill in the following information if available:

Result of last GXT _____
Blood pressure _____
Glucose _____
Total serum cholesterol _____
HDL-C _____ LDL-C _____
Triglycerides _____

Physician's Signature _____ Date _____

Please Note: This record must be signed by the physician or at least stamped by the physician and verified if stamped by a typed letter on the provider's letterhead. THE PHYSICIAN'S CLEARANCE FORM WILL NOT BE ACCEPTED WITHOUT SUCH PROPER VERIFICATION.