JUPITER MEDICAL CENTER

PHYSICIAN STATEMENT & CLEARANCE FORM

PLEASE CLEAR FOR: ___ **WELLNESS CENTER**
___ **AQUATIC CENTER**

Patient: _____
Telephone Number_____ D.O.B. ____/____/____

Your patient is interested in participating in the Health & Rehab program at Jupiter Medical Center. The focus of our program is

- prevention,
- risk reduction
- education
- lifestyle modification
- improve health status.

Based on information obtained in our health history questionnaire, your patient has been found to have risk factors :

_____ _____ _____.

A medical approval is requested for your patient to participate in an individualized exercise program.

This approval indicates that your patient is medically stable to participate. Please indicate any restrictions below. Thank you.

PLEASE CHECK THE APPROPRIATE BOX BELOW:

( ) **IS CLEARED WITHOUT RESTRICTIONS** to begin or continue a prescribed exercise program.

( ) **IS CLEARED WITH THE FOLLOWING RESTRICITONS** to resume his/her exercise program _____

( ) **IS <u>NOT</u> CLEARED TO USE THE SPA.** Spa temperature is maintained at 102 degrees.

( ) **SHOULD HAVE A PHYSICIAN SUPERVISED** graded exercise test.
(This test is not provided in this facility.)

( ) **SHOULD NOT PARTICIPATE IN AN EXERCISE PROGRAM AT THIS TIME**

( ) **Other** _____

Physician Signature_____ Date_____
Physician Name _____ Phone_____
Address_____ Fax_____
City_____ State____ ZIP_____

Return form to: Jupiter Medical Center, Health & Rehab
1004 S. Old Dixie Hwy.
Jupiter, FL 33458
561-263-5770, Fax: 561-263-5776

Faxed:

__/__/__