Medical Clearance Form

Date:_____

Dear Physician:

Your patient _____ would like to begin an exercise program at our facility for individuals with Parkinson's disease. We require medical clearance and recommendations concerning participation in a regular exercise program. Please provide the following information and return this form to:

Name: Rock It Out, Inc.

Address: 18626 Detroit Ave.,Lakewood, OH 44107

Phone: (216) 383-6232

Email: Maria@rockitout.org

Are there specific concerns or conditions our staff should be aware of before this individual engages in regular exercise at our facility? Yes No

If yes, please specify:

Physician/NP/PA signature: _____

Provider's name: _____ **Phone:**_____

Address: _____

PARTICIPANT RELEASE AUTHORIZATION

I hereby authorize release of medical information pertinent to restrictions for my exercise program as determined necessary by my healthcare provider.

PARTICIPANT SIGNATURE DATE