

Physical Activity Medical Clearance Form

Indian Health Care Resource Center of Tulsa

Medical Providers: Please complete this form for your patient who is interested in participating in the Running Strong Program. This will convey your clearance for the patient to participate in a moderate to intense exercise program, and provide a place for you to indicate health risks and restrictions as needed. Thank you for your time.

This section to be completed by the participant:

Name _____ Date of Birth ____/____/____

Address _____
Street City State Zip

Phone number ____ - ____ - _____

Physician's Name _____

Office Address _____
Street City State Zip

Office phone number ____ - ____ - _____

Medical Provider please complete this section:

Patient's Current Health Habits & Risk Factors:

- ____ Less than 30 minutes per day of moderate physical activity 3 days per week
- ____ Hypertension
- ____ Hyperlipidemia
- ____ Diabetes – Type 1
- ____ Diabetes – Type 2
- ____ Muscular/skeletal condition
- ____ Overweight/obesity
- ____ Arthritis
- ____ Asthma
- ____ Seizures
- ____ Emotional/behavioral disorders _____
- ____ Allergies _____
- ____ Other _____

Height & Weight: _____ inches _____ pounds

This patient is taking the following medications:

Based on the above health habits & risk factors, medical provider recommends:

- ____ Unrestricted physical activity
- ____ Restricted physical activity:
 - Maximum heart rate _____ beats/minute
 - Activity limited to _____
 - Other restrictions _____

Medical Provider Signature

____/____/____
Date