

PHYSICIAN APPROVED EXERCISE CLEARANCE FORM
Ball State University / College of Applied Sciences and Technology
School of Physical Education, Sport and Exercise Science
(please print)

Name _____ Date _____ Class / Course _____

Student ID# _____ Age _____ Date of last medical check up _____

This form is designed for individuals with special health concerns to assist your instructor in individualizing your fitness program according to your physician's recommendations.

This section is to be completed by the LAB Instructor:

(Name of Student) _____ is presently enrolled in (Name of Course) _____ and he/she has identified health problems on the Student Precourse Health Assessment Form that may affect participation in the activities of this course. This class / course will include the following activities:

The above information was provided by (instructor's name) _____ Date _____

This section is to be completed by the Physician:

NOTE TO PHYSICIAN: PLEASE REVIEW THE STUDENT PRECOURSE HEALTH ASSESSMENT FORM

After reviewing the form, I recommend the following level of participation:

___ Full Participation ___ Modified participation as indicated (Please indicate below): ___ No Participation

Signature of Physician

Date (mm/dd/yy)

Physician's Printed Name

Physician's Fax Number

Physician's Phone Number