



PHOENIX COLLEGE

MEDICAL RELEASE

1202 West Thomas Rd.
Phoenix, AZ 85013
PHONE : 602-285-7295
FAX : 602-285-7755

It is my understanding that, _____,
may be participating in exercise and/or fitness activities at Phoenix College and has been
referred to a health care practitioner for medical clearance.

As the participant's attending physician, I am aware of medical condition(s) that would
limit his/her activity. Therefore, I recommend that this patient NOT participate in the
following activities (please check box):

Cardiovascular

- Treadmill
Stationary bike
Recumbent bike
Stair climber
Rowing machine
Elliptical trainer
Air Dyne bike

Strengthening

- Lifting weights
Arms - R or L
Abdominal
Chest
Upper back
Lower back
Shoulder - R or L
Legs- R or L

Aerobics

- Step aerobics
Low impact aerobics
Stability ball
Stretching exercises
Chair exercises
Kickboxing
Yoga/Pilates
Martial arts

Specific comments regarding limitations or contraindications for activity:

Phone # _____

Physician's Signature

Date

You may mail or fax to: Phoenix College - H.P.F.W. Dept.
1202 W. Thomas Road, Phoenix, AZ 85013
PHONE: (602) 285-7295 FAX: (602) 285-7755

I, _____, hereby give my permission to
release any pertinent medical information to the staff in the Health Professions, Fitness &
Wellness Department at Phoenix College. All information will be kept confidential.

Patient's Signature: _____ Date: _____

Address: _____

Birth Date: _____ Telephone #: _____

Physician Name (first / last): _____