



Kinesiology, Sport Studies and Physical Education

**Physician's Statement and Clearance Form  
The College at Brockport – Exercise Science Employee Fitness Program**

At The College at Brockport – Exercise Science Employee Fitness Program, your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine and the International Health, Racquet and Sportsclub Association.

On the Health History Questionnaire you just completed, you identified that you have one or more coronary and/or other medical risk factors that may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin exercising a The College at Brockport – Exercise Science Employee Fitness Program.

We recognize that you are eager to start your fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience at The College at Brockport - Employee Fitness Program to be as safe as possible.

In order to expedite this process, we will gladly fax this form directly to the physician of your choice. If the doctor is aware of your medical history, he/she may be able to complete this form and fax it right back to us. In many cases the delay is only one day.



The College at  
**BROCKPORT**  
STATE UNIVERSITY OF NEW YORK

Kinesiology, Sport Studies and Physical Education

**I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at The College at Brockport – Exercise Science Employee Fitness and Wellness Center. All information will be kept confidential.**

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Information requested for \_\_\_\_\_

Reason for medical clearance \_\_\_\_\_

Physician's name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

***For Physician Use Only***

Please check one of the following statements.

\_\_\_ I concur with my patient's participation with no restrictions.

\_\_\_ I concur with my patient's participation in an exercise program if he/she restricts activities to:

\_\_\_\_\_

\_\_\_ I do not concur with my patient's participation in an exercise program (if checked, the individual will not be allowed to join, The College at Brockport – Exercise Science Employee Fitness Center)

Reason

\_\_\_\_\_

Physician's name (type or print) \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return fax to:** Director of Program, Elizabeth K. Lenz, Ph.D.

**Phone** (585)395-5266 **Fax** (585) 395-2771