After Therapy Club Physician Clearance

Participant's Name:____Date of Birth: ________

Address:____

Telephone Number: ______________________________

Medical Condition(s) which could impact, or be a concern for, an exercise/conditioning program for this participant (please list):

Cardio-Pulmonary: ____

Joint Problems: ____

Other: ____

Exercise/Conditioning Restrictions (If any):

Lifting/resistance: ____

Other: ____

The above named individual is able to participate in the After Therapy Club at the Regional Therapy Center of Saratoga Hospital.

No special monitoring is necessary and supervision is not required as this individual is able to participate in the After Therapy Club independently.

Physician:_______________________________________ Date:________________