

Medical Clearance Form

The participant below has answered **Yes** to one or more pre-screening questions. We require medical clearance to enable us to assess if safe to participate in a mobility, balance and/or resistance-based exercise program.

|  |
| --- |
|  **Participant details – to be completed either by the participant or the doctor**  |
| Surname: |  Given Name: ………………………………. |
| Gender: | ……………… | …………………. ……… |  Date of Birth:  |
| Phone: | ……………… | …………………………… |  Date of Assessment:  |

|  |
| --- |
|  **Person to be notified in case of emergency**  |
| Surname:  | Given Name: |
| Phone:  | Relationship: |

 **Doctor to complete this section**

1. The participant is able to safely participate in a **walking program?**

|  |  |  |
| --- | --- | --- |
| Yes – no limitations | Yes – with limitations (please specify) | No, cannot participate |
| Limitations: |  |  |

1. The participant is able to safely participate in a **movement and balance program?**

|  |  |  |
| --- | --- | --- |
| Yes – no limitations | Yes – with limitations (please specify) | No, cannot participate |
| Limitations: |  |  |

1. Does the participant have diagnosed muscle, bone or joint problems that can be made worse?

|  |  |  |
| --- | --- | --- |
| Yes – no limitations | Yes – with limitations (please specify) | No, cannot participate |
| Limitations: |  |  |

|  |
| --- |
| **4.** Other relevant health conditions? |
|  |
| **5.**  Relevant medications? |

|  |  |  |
| --- | --- | --- |
| Doctor’s Signature: |  | Date: |
| Doctor’s Name: |  | Phone: |
| Address: |  | If you require more information on the components or the level of supervision forthe program, contact : Cancer Council ACT Phone: 02 6257 9999 orEmail: reception@actcancer.org |
| (or apply address stamp) |

**Please complete and return this form by** email: reception@actcancer.org or fax: 02

6257 5055 or post: Cancer Council ACT, PO Box 75, Deakin, ACT 2600.