

Medical Authorization for Exercise Class Participation The Fitness Clinic for Individuals with Disabilities

The individual listed below has expressed an interest in participating in an activity class offered through the Fitness Clinic for Individuals with Disabilities at San Diego State University. This class promotes fitness, wellness and preventative healthcare through the utilization of specific exercises and activities. Constant supervision will be provided by the instructor and Exercise & Nutritional Science students.

Patient's Name: _____

Physician's Name: (Please Print) _____

Physician's Address & Phone Number: _____

Patient's Diagnosis(es): _____

Exercise/Activity Recommendations: _____

Contraindicated Exercises/Activities: _____

I recommend that this individual participate **without** limitation.

I recommend that this individual participate with the following

limitations/considerations: _____

I DO NOT recommend that this individual participate in an exercise program.

Please call for recommendations () _____ Time: _____ Date: _____

Physician's Signature: _____

Date: _____