Adelaide University

Dear Doctor,
Your Patient is interested in participating in a regular exercise program at an Adelaide University gym.

Please provide the requested information to assist our Fitness Instructors in conducting a pre-exercise health and fitness consultation and designing a safe, suitable exercise program.

All information will be treated as strictly confidential.

Thank you for your cooperation.

Pre-Exercise Medical Clearance

Patient Name	**Date of Birth**

Patient Medication and Effects

Resting Blood Pressure	**Resting Heart Rate**	**Cholesterol (optional)**
Systolic / Diastolic	BPM	mmol/1

Details of any pre-existing medical conditions or injuries:

_____
_____
_____

Your Recommendations Regarding an Exercise Program:

_____
_____
_____

Physician Name & Clinic Address	**Phone No.**	**Physician Signature**
	Fax No.	

Adelaide University acknowledges and respects the privacy of individuals. The information that is being collected on this document is for the purposes of providing an appropriate exercise plan specific to the individual's needs. The personal and health information collected is required to determine pre-existing conditions, which may influence the individual's ability to participate in a program. By completing this form, Adelaide University accepts that the individual, or individual's parents/ guardians (if a person under the age of 18) have consented for this information to be collected. The intended recipients of this information are Adelaide University and its authorised staff. You have the right to access and alter personal or health information concerning in accordance with the Commonwealth Privacy Act (Amended 2001) and Adelaide University.