



PHYSICIAN'S STATEMENT AND CLEARANCE FORM

At Revolution Pilates Studio, your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine.

On the Initial Assessment or Floor Class Questionnaires you have completed, you identified that you have two or more coronary and/or other medical risk factors which 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 are able to exercise at the studio.**

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 Revolution Pilates Studio to be as safe as possible.

In order to expedite this process, please send or fax this form directly to your physician and have him or her complete and return this form to the fax number below.

I hereby give my physician permission to release any pertinent medical information from any medical record to the staff at Revolution Pilates Studio. All information will be kept confidential.

Client's Name (Please Print) Phone Number.....

Client's Signature Date

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 Revolution Pilates Studio

Reason

Physician's Name.....

Physician's Signature Date

Please fax to the number below. Thank you for your time.

The Pilates Method • GYROTONIC® & GYROKINESIS® Yoga • Fitness Rehabilitation

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