Department of Kinesiology, California State University, Northridge
CENTER OF ACHIEVEMENT/BROWN CENTER
Adaptive Physical Activity
18111 Nordhoff Street, Northridge, CA 91330 -8287
Phone (818) 677-2182 Fax (818) 677-3246

MEDICAL RELEASE FORM

(Revised 7/1/20)

Legal Name of Client:_____DOB_____
(Print) Last Name First Name

To: Attending Physician

The Center of Achievement is providing an exercise program for your patient. The program may include exercises for improved muscular strength, range of motion, cardiovascular endurance, posture and balance.

The Center of Achievement requests that you provide any medical information, which would affect the selection of activities (**in-person or virtual**). All medical records will be handled in strict confidence. Original document must be completed and signed by physician before submitting to the center. Thank you for your assistance.

Please complete items I, II, & III below as applicable:

I. Primary Physical Disability: _____

Secondary Medical Diagnosis: _____

II. Client is prone to seizures: ☐ NO ☐ YES frequency of seizures_____

III. Client is **medically cleared** for the following program(s):

❑ **Gym Exercise Program**	❑ **Aquatic Exercise Program**	❑ **Both Gym & Aquatic Program**	❑ **Virtual Program**	❑ **None**

GYM EXERCISE PROGRAM Patient **IS NOT CLEARED** for the following exercises	**AQUATIC EXERCISE PROGRAM** Patient **IS NOT CLEARED** for the following exercises
❑ No Strength Training Exercises	❑ No Strength Training Exercises
❑ No Partial Weight Bearing (i.e. tilt table)	❑ No Assistive Weight Bearing
❑ No Stretching Exercises Active/Passive	❑ No Stretching Exercises Active/Passive
❑ No Cardiovascular Exercise	❑ No Cardiovascular Exercise
	❑ No Submersion
	❑ No Deep Water Exercise

IV. Please give a brief explanation for above restrictions and/or your recommendations.

(Example Max Working Heart Rate)_____

_____

Print Physician's Name: _____ **Date**: _____
Address, city, state, zip code: _____
Physician's Signature: _____, **M.D. Specialty: _____**
Phone: _____ FAX: _____

*For office use only: Reviewed by:*_____ *Date:* _____