City Centre Community Association

5900 Minoru Blvd.
Richmond, BC
V6X 0L9

Tel: 604-204-8588
Fax: 604-204-8589

Dear Doctor:

Re: Osteofit Medical Clearance Form

Please complete, sign and date stamp the attached Osteofit Medical Clearance form and fax to:

Teri Lee Sampson
Fitness Coordinator
City Centre Community

FAX: No. 604-204-8589

Office Use Only

Client Name:_____ Client ID:_____

Client Phone No:_____

Clearance Form Expiry Date:_____

Date Entered into CLASS:_____ Entered by:_____

Distribution:

- ☐ Update CLASS / Original to Fitness Coordinator
- ☐ 1 copy to Osteofit Instructor Binder

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BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Osteofit fitness and healthy bones

Medical Clearance Form

Dear Doctor _____,

Your patient _____wishes to participate in BC Women's Hospital & Health Centre's Osteofit exercise program. This program will include interactive discussions on topics pertaining to lifestyle management of osteoporosis, agility activities, balance exercises, strengthening exercises, and stretches, all designed to be safe for those with osteoporosis.

After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advice in setting limitations to their program. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize Dr. to release to **City Centre Community Centre**, health information concerning my ability to participate in an exercise program.

Member's signature:_____ Date:_____

Member's Phone Number:_____ Trainer'signature:_____

Physician's Recommendations

☐ I am not aware of any contraindications toward participation in the Osteofit program.

☐ I believe the applicant can participate, but urge caution because: _____

_____

☐ The applicant should not engage in the following activities:_____

_____

☐ I recommend the applicant not participate in the above exercise program.

Physician's signature:_____ Date:_____

Physician's name (print):_____ Phone/Fax:_____