

Medical Release Form

All Participants of **WellFit** Lifetime Wellness Program are **REQUIRED** to submit this form.

Full Name

Address

City State Zip

Phone (W) (H)

Email

1. ? **Yes** ? **No** Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by a doctor?
2. ? **Yes** ? **No** Do you feel pain in the chest when you do physical activity?
3. ? **Yes** ? **No** In the past month, have you had chest pain when you were not doing physical activity?
4. ? **Yes** ? **No** Do you lose your balance because of dizziness or do you ever lose consciousness?
5. ? **Yes** ? **No** Do you have bone or joint problems that could be made worse by a change in your physical activity?
6. ? **Yes** ? **No** Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
7. ? **Yes** ? **No** Do you know any other reason why you should not do physical activity?
8. ? **Yes** ? **No** Are you a female over the age of 50?
9. ? **Yes** ? **No** Are you a male over the age of 40?

If you answered “**YES**” to any of these questions, you *must* have your physician’s consent to participate in **WellFit**. Please ask him/her to complete the clearance form ([click here for the form](#)). If you answered “**NO**” to all of the questions, you do not need to have your physician’s permission to participate in the exercise program, but you still need to return this form. Thank you!