**MEDICAL CLEARANCE FORM**

**CLUB 60 PLUS FITNESS CENTER**

**Wallingford Senior Center**

238 Washington Street

Wallingford, CT 06492

Phone: 203 265-7753

Fax: 203 294-2117

Email: [office@wlfdseniorctr.com](mailto:office@wlfdseniorctr.com)

Dear Doctor:

Your patient has requested to join the Wallingford Senior Center’s fitness center which contains both cardio and weight resistance equipment, and we require a signed Physician’s Medical Clearance form prior to becoming a member and using the equipment. The cardio equipment includes: treadmills; elliptical trainers; recumbent cross trainers; recumbent cycle; and ergometer. The weight resistance equipment includes: multi press; seated leg extension/leg curl; incline leg press/calf raise; multi ab/back; lateral pulldown/row; multi bicep/tricep; and assorted dumbbells.

Although your patient will be instructed by a certified fitness trainer as to the proper and safe operation of all equipment, please note, this is an **unsupervised** fitness center.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approval: I approve this applicant’s participation in the Wallingford Senior Center’s CLUB 60 PLUS Fitness Center.**

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_