PRISMA HEALTH SM

www.ghs.org/lifecenter

Life Center
Medical Clearance

Office Use:
Fax Number; _____
Office Number: _____
Date Faxed: _____
Staff Initials: _____

Date:_____/_____/_____

Dr._____,

Your patient,_____, D.O.B._____/_____/_____, would like to participate in exercise activities at the LIFE CENTER HEALTH & CONDITIONING CLUB, a non-clinical health and fitness facility that provides a variety of exercise activities. To comply with physical activity prescreening recommendations established by the American College of Sports Medicine, we ask all participants to complete a brief health history questionnaire. Based on his/her responses, your patient needs to obtain medical clearance prior to participating in exercise activities. We would appreciate your medical opinion and recommendations concerning his/her participation.

PLEASE CHECK ONE

☐ Patient is cleared to participate in exercise activities with no restrictions.
☐ Patient is limited with the following restrictions:

_____

_____

_____

☐ Patient cannot participate in exercise program. Recommendations are as follows:
- ☐ Graded Treadmill Test
- ☐ HeartLife (cardiac rehabilitation)

Additional Comments:

_____

_____

_____

Physician signature:_____Date:____/____/____

875 W. Faris Road, Greenville, SC 29605
Phone (864) 455-4020 ● Fax (864) 455-1596