The Empowerment Neurofitness and Wellness Center

Medical Clearance Form for Exercise

To be completed by Primary Care Physician or Neurologist

Patient Name: _____ Date: _____

Date of Birth: _____/_____/_____ Height: _____ Weight:_____ Resting Pulse:_____ Blood Pressure:____/_____

Diagnosis:

Parkinson's Disease Symptoms: _____
Stroke
Multiple Sclerosis
Other: (Explain disability and cause)

_____
Date of Onset or Diagnoses:
Dates of hospitalization in past two years with admitting diagnoses:
Medications (please attach if appropriate) _____
Allergies: _____

Please indicate if applicable:

Seizures:	YES	NO	How many in the last 12 months:		Date of most recent seizure
Diabetes	YES	NO	Use Insulin:	YES	NO
Heart Disease	YES	NO	High Blood pressure:	YES	NO
Asthma:	YES	NO	Heart related problems:	YES	NO

Other:

Comments/Restrictions: _____
_____

Physician Name: (Print) _____

Email address: _____ Nurse: _____

APPROVAL FOR PARTICIPATION: YES NO

Physician's Signature: _____**Phone:** _____

Mail/Fax/Email completed form to:
The ENFWC
4402 Princess Anne Road, Suite 105
Virginia Beach, VA 23462

Email: info@enfwc.org
FAX: 434-277-6136
Phone: 757.474.6300