



Physician Clearance Form

To be filled out by patient's primary health care provider

Your patient, has indicated "yes" to one or more of the following health conditions (as indicated below). In order to begin a general exercise program at GoKids Youth Research and Training Center, please indicate whether your patient may participate in moderate to vigorous aerobic and strength-type exercise, with or without any restriction.

Heart Disease	<input type="radio"/> Yes
Diabetes/ High Blood Sugar	<input type="radio"/> Yes
High Blood Pressure	<input type="radio"/> Yes
Seizure	<input type="radio"/> Yes
Asthma or Other Lung Condition	<input type="radio"/> Yes
Cancer	<input type="radio"/> Yes
Musculoskeletal Condition or Injury	<input type="radio"/> Yes
Other Serious Illness	<input type="radio"/> Yes
Allergy	<input type="radio"/> Yes

_____ I **agree** with my patient's participation in GoKids Boston's exercise programs **without any restriction**.

_____ I **agree** with my patient's participation in GoKids Boston's exercise programs **with the following restrictions**:

_____ I **do not agree** with my patient's participation in GoKids Boston's exercise programs at this time (if checked, the patient will not be allowed to join GoKids Boston).

Is there any other information you would like to share with us to help provide a safe and effective exercise program for this patient?:

Please fax or mail to:

GoKids™ Boston

University of Massachusetts Boston

100 Morrissey Boulevard Boston, MA 02125-3393

Phone: 617.287.KIDS [617.287.5437]

Fax: 617.287.6165