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MEDICAL CLEARANCE FORM

Client Information:

Last Name: _____ First Name: _____

Full Mailing Address: _____

City/town: _____ Postal Code: _____ Phone #: _____

Emergency Name/ Contact Number: _____

Medical Information:

Date: _____

Prescribed Target Heart Rate: _____

Blood Pressure: _____ On medication ? YES NO

Limitations:

Recommendations:

Doctor's signature:

STAMP

Dr.'s Name: _____ Phone Number: _____
Address: _____

*Vitality Fitness Inc. is not responsible for charges incurred to clients as a result of having medical clearance completed.

Vitality Fax: 613-258-4080