PROVIDER MEDICAL CLEARANCE FORM

Dear Provider:

Your patient wishes to participate in one or more BFMC Exercise Programs. If your patient does not have any known contraindications to exercise, and you feel your patient is an appropriate candidate to join in our exercise programs, please complete this form and mail it to our Health Education Department at 4570 California Ave, 1st Floor, Bakersfield, CA 93309, or fax to 661-846-4658. Please make any recommendations or restrictions that are appropriate for your patient's participation in the space provided.

Thank you for your assistance in screening your patient for participation in these exercise programs. If you have any questions regarding our programs, please call the Health Education Department at 661-846-4650.

Patient Name (Print)_____ DOB_____

_____Patient ***cannot*** participate in any exercise program at this time.

_____Patient is cleared to participate in BFMC -Health Education's Exercise Programs ***without*** restrictions.

_____Patient is cleared to participate in BFMC -Health Education's Exercise Programs ***with the following restrictions***:

_____

_____ _____

Provider Name (Print) **Provider Signature** **Date**

PATIENT INFORMED CONSENT AND RELEASE

I desire to voluntarily participate in one or more of the Exercise Programs at BFMC in order to improve my overall fitness level. To participate in these programs, I verify that I am in good health with no known contraindications to exercise. I will notify my Primary Care Physician of my wish to participate in these programs prior to the start date to get written Medical Clearance from my PCP. I understand that the exercise programs include various exercise and activities in which I may choose to participate.

I understand that I must follow the exercise and activity program guidelines which may be set in place for me by my PCP. In addition, I will be instructed regarding signs and symptoms of any activities that may affect my personal well being (for example: nausea, dizziness, shortness of breath, chest pain or pressure, irregular heart rate, leg cramps, etc). If I experience any of these signs or symptoms, I will report them immediately to the instructor and stop my exercise immediately.

I have read and understand all the information contained in this release form. Any questions that have occurred to me regarding these exercise programs have been answered to my satisfaction. I hereby consent to participate in one or more of BFMC's Exercise Programs by signing this Informed Consent and Release form below.

I, for myself, my heirs, executors and administrators, hereby fully waive and release any and all rights, claims of damage, liabilities or actions, whether known or unknown, that I have against my Medical Group and/or Physician, and the Bakersfield Family Medical Center.

_____ _____

Name (Print) Date of Birth

_____

Address City State Zip Code

_____

Phone Number

_____ _____

Signature Date

FOR HEALTH EDUCATION OFFICE USE ONLY

Reviewed by:

_____ _____

Name (Print) Signature/ Date

12/2021