Albert Pujols
Wellness Center for *Adults* with
Down Syndrome

Medical Clearance Form

Name: _____DOB:_____

Height: _____ Weight: _____ BP: _____/_____

Date of last physical: _____

Has the client received their COVID vaccine? _____ Date: _____

I acknowledge that it is my responsibility to notify the Wellness Center staff of any changes with the client's medical or mental health status.

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Parent/Guardian Signature: **Date:**

Current Medical Problems:

_____

_____

Additional Past Medical History (including any cardiac history):

_____

_____

Is there history of Atlanto-Axial instability? Yes No

Are you aware of any medical problems that are a contraindication for this patient to participate fully in a supervised exercise program? Yes No

Hatha Yoga: Yes No

Group Fitness Circuit Exercises: Yes No

Kickboxing: Yes No

In your medical opinion is patient able to participate in exercise classes without restrictions?
Yes No

If yes, please list any restrictions:

_____

_____

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Physician's signature required to participate in ADS fitness classes **DATE**

Physician's printed name Phone number

Revised 3/12/2021