Medical Clearance Form Template

Patient Information

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Medical History

1. **Current Medications: _____**
2. **Past Surgeries: _____**
3. **Allergies: _____**
4. **Chronic Conditions: _____**

Physician's Evaluation

Physical Examination Summary:

- **Heart Rate: _____ BPM**
- **Blood Pressure: _____ mmHg**
- **Respiratory Rate: _____ BPM**
- **Temperature: _____ °F**

Assessment

Physician's Notes:

Physician's Declaration

I certify that the above-named patient is medically cleared for:

[ ] General Activities

[ ] Specific Activities: _____

Physician's Signature: _____

Date: _____