Fit-Tech Consulting, Ltd.

Medical Release for Fitness Assessment

Last Name	First Name	Initial	Date of Birth

Circle one item in each column for the condition that best applies:

Tobacco Use	Work Exertion	Exercise Habits
Non User	Intensive occupational exertion	Intensive recreational exertion
Cigar, pipe or chew	Moderate occupational exertion	Moderate recreational exertion
< 10 cigarettes per day	Sedentary work	Light recreational exertion
20 cigarettes per day	No occupational exertion	No recreational exertion
30 cigarettes per day		
> 40 cigarettes per day		

In Past: Date quit smoking:______ Number of years smoked:______ Avg. # of packs smoked per day:______

Par-Q Pre-Testing Participation Questionnaire (Circle each answer Yes or No)

Yes No 1. Has your physician ever said that you have a heart condition?
Yes No 2. Do you feel pain in your chest when you do physical activity?
Yes No 3. In the past month, have you had chest pain when you were doing physical activity?
Yes No 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
Yes No 5. Do you have a bone or joint problem that could be made worse by physical activity?
Yes No 6. Is your physician currently prescribing drugs for your blood pressure or heart condition?
Yes No 7. Is there any other reason why you should not participate in a strenuous fitness test?

Certification and authorization

- I am aware that the fitness assessment used by Fit-Tech, as described to me, is a demanding series of tasks.
- I hereby certify that it is safe for me to complete the tests as described in the Fit-tech website and information sheet, which I have read.
- The above information has been discussed with a physician and all answers are provided truthfully and to the best of my knowledge.
- I hereby authorize the physician to release the information on this form to Fit-Tech Consulting Ltd.

Signature of applicant: ______________________________ Date: ____________________

Information below is to be completed only by the Physician

Height_____in Weight_____lbs Systolic BP______ Diastolic BP______ Heart Rate_____bpm

Physicians Opinion: Approved for fitness testing at prolonged high exertion levels.
Yes No

Signature of physician: ______________________________ Date: ____________________

Physicians: Name / Address / Tel / MSP#
(Stamp or Print)