



**Parkinson's
Nebraska**

A Journey Shared

Physician Statement and Clearance Form

At Parkinson's Nebraska safety is our primary concern. For this reason, all participants must have a physician complete and return this medical clearance form before you can begin taking classes supported by Parkinson's Nebraska. We realize that you are eager to start your fitness program, however, Parkinson's Nebraska wants your exercise experience with us to be as safe as possible.

I hereby give my permission to release any pertinent medical information from any medical records to the staff and instructors at Parkinson's Nebraska. All information will be kept confidential.

Patient's Name _____

Patient's Signature _____ Date _____

Reason for medical clearance _____

Physician's Name _____ Phone Number _____

Physician Address _____

For Physician Use Only:

_____ I concur with my patient's participation with no restrictions.

_____ I concur with my patient's participation in an exercise program but with the following concerns, limitations, or restrictions (Please include issues such as joint problems, diabetes, coronary disease, back problems, etc that might impact or limit the patient's ability to exercise):

___ I recommend that this patient NOT participate in this exercise program.

Comments:

Physician's Signature _____ Date _____

Please fax, mail or email completed forms to:

Amie Prendes, Administrator

Parkinson's Nebraska

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