ILLINOIS

**Lifetime Fitness Program**
University of Illinois at Urbana-Champaign
Department of Health and Kinesiology
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Address: *906 S. Goodwin Ave. Urbana, IL 61801*

MEDICAL RELEASE FORM 2026-2027

**To the Attending Physician of Mr./Ms.** _____
*Patient Name* *Birth Date*

**Patient is classified as:** (*Please check one*)
_____ New enrollee in the Lifetime Fitness Program
_____ Continuing participant in the Lifetime Fitness Program

*Patient understands that a medical examination is required before participation is permitted*

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**To be completed by the attending physician**

*The above-named individual has asked to participate in the Lifetime Fitness Program. Exercise classes within the Lifetime Fitness Program operate 3-5 days per week (depending on the academic year) for 1-2 hours, and may involve moderate/strenuous exercise in the form of brisk walking/jogging, aquatic exercise, weight training, balance and flexibility training. Additionally, members may exercise at their own pleasure independently at Campus Recreation Facilities.*

**Please indicate the conditions that apply to your patient. Leave those that do not apply blank.**

| | |
|---|---|
| **1. Cardiovascular Disease**<br>**Dx:**<br>**Treatment:** | **7. CNS Disorder**<br>**Dx:**<br>**Treatment:** |
| **2. Hypertension**<br>**Dx:**<br>**Treatment:** | **8. Chronic Respiratory Conditions**<br>**Dx:**<br>**Treatment:** |
| **3. Disorders of Hearth Rhythm (transient or chronic)**<br>**Dx:**<br>**Treatment:** | **9. Obesity**<br>**Dx:**<br>**Treatment:** |
| **4. Diabetes (Please circle: Type 1 or Type 2)**<br>**Dx:**<br>**Treatment:** | **10. Cancer**<br>**Dx:**<br>**Treatment:** |
| **5. Hyperlipidemia**<br>**Dx:**<br>**Treatment:** | **11. Other(s)**<br>**Dx:**<br>**Treatment:** |
| **6. Musculoskeletal Functional Impairment**<br>**Dx:**<br>**Treatment:** | **12. Other(s)**<br>**Dx:**<br>**Treatment:** |

PLEASE TURN OVER

**Current Medications:** _____

_____

**Known Drug Allergies**: _____

_____

**Prior or Current Injuries**: _____

_____

**The above-named individual is capable of:**

Unlimited physical activity: _____
Limited physical activity: _____
No exercise program: _____

If the participant is cleared for limited activity, please offer exercise guidelines:
_____
_____
_____

_____

*Physician's Name (please print)* *Phone Number* *Hospital/Office*

_____ _____

*Physician's Signature* *Date*

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*(Office Use only)*
*LFP Staff Initials and date entered into database:*_____