

**Cuba-Rushford CSD
Community use of Weight Room
Physician's Medical Clearance Form**

Name: _____ has requested use of the school's fitness center. A description of the equipment and exercise activities that are available is described in the attached brochure and explained to the participant in the orientation session. The school's fitness room is supervised by school personnel. If you know of any medical reason why participation by the applicant would be unwise, please indicate so on this form. If you have any further questions about the facility, its equipment or activities, please call the school at:

585-968-2650 x4420
Josh Tompkins
5476 Route 305
Cuba, NY 14727
jtompkins@crcs.wnyric.org

Physician's Report

I, _____ (Physician's name) give my consent for
_____ (Member's name) to use the school's
fitness center and participate in exercise activities.

Specific Recommendations:

Restrictions:

Physician's Signature: _____

Physician's Printed Name: _____

Physician's Address: _____

Physician's Phone Number: _____ **Date:** _____

PLEASE RETURN COMPLETED FORM TO SUPERINTENDENT'S SECRETARY