



## Physician Clearance Form

**The Outpatient Rehabilitation Center at South Shore Hospital is offering a five-week gym/pool community exercise program. Participants must be able to perform exercises independently and be free of the contraindications listed below if in a pool program.**

**If this patient requires individualized attention, a physical therapy evaluation can be scheduled. A separate order is needed for this.**

**My patient, \_\_\_\_\_ has medical clearance to attend South Shore Hospital's Community Exercise Program.**

**Please indicate if there are any special precautions or considerations for this individual to limit his/her participation in the program.**

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**Absolute contraindications to participation in water:**

- 1. Fever over 100 degrees Fahrenheit.**
- 2. Uncontrolled epilepsy.**
- 3. Cardiac failure.**
- 4. Incontinence of bowel or bladder.**
- 5. Respiratory disease where vital capacity is less than 1500 cm<sup>3</sup> and careful screening with capacity of less than 1 liter.**
- 6. Menstruation without internal protection.**
- 7. Weeping skin infections or open wounds.**

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

**Fax number: (781)340-3518 attn: Amy Williams  
Please call (781)340-8177 with questions.**