

BIO BLUEPRINT | HUMAN PERFORMANCE LAB

Medical Clearance for Exercise Testing & Physical Activity

Client name: _____ Date of birth: _____

Proposed appointment date: _____ Referring clinician: _____

Requested services (check all appropriate): ☐ Incremental VO₂peak/VO₂max exercise test ☐ Submaximal exercise ☐ Strength and balance measurements ☐ Functional movement screening ☐ Other: _____

This form requests medical input about participation in non-diagnostic exercise testing and exercise services. It is not a substitute for appropriate clinical evaluation, emergency care, or Bio Blueprint's own safety screening and test-day decisions.

Clinician determination

☐ No medical contraindication identified to the selected activity/testing described above, subject to usual screening and on-site safety decisions.

☐ May participate with the following restrictions / modifications (specify below).

☐ Defer participation pending further evaluation. ☐ Not cleared for the requested activity/testing at this time.

Relevant exercise precautions, restrictions, intensity limits, or monitoring needs:

If relevant: pregnancy-related limitations, orthostatic intolerance, medication effects, exertional symptoms, or other considerations may be noted here only as clinically necessary for testing safety.

Clinician name / credentials: _____

Practice / telephone: _____

Clinician signature: _____ Date: _____

Client authorization (optional if clinician requires): I authorize my clinician to return this form to Bio Blueprint by an agreed secure channel. Signature: _____ Date: _____

Return instructions

Bring the signed form to the appointment or submit it ahead of time through the secure method designated by Bio Blueprint. Do not send clinical details through ordinary website contact forms or unsecured email. A form does not guarantee testing; testing may be modified or declined based on symptoms, protocols, or staff judgment.

Business contact and secure submission method: [COMPLETE BEFORE PUBLISHING]