MEDICAL CLEARANCE FORM

Date: _____ Physician's Name: _____

Client's Name: _____ Physician's Phone: _____

Client's Phone: _____ Physician's Fax: _____

Client's DOB: _____

Dear Doctor:

Your patient _____ has requested to participate in LIVESTRONG at the YMCA, a cancer survivor exercise and support program. At the start of this program, your patient will participate in a fitness assessment, including the 6 minute walk test, one repetition max test for upper and lower body, and a balance and flexibility test. Following the fitness assessment, your patient will partake in cardio-respiratory fitness, muscular strength and endurance, and flexibility and balance exercises. A specific, individualized exercise program will be created for the participant, based on the needs, interests and any recommendations you may have. The LIVESTRONG at the Y program is designed to start easy and become progressively more difficult over a 12-week program duration. All fitness assessments and exercise activities will be administered by qualified personnel trained in conducting exercise tests and programs.

Based on the LIVESTRONG at the YMCA intake form, your patient has indicated a diagnosed medical condition, coronary risk factor and/or health condition that requires a physician's clearance prior to participation in this program.

By completing the form below, you are not assuming any responsibility for our administration of the fitness assessment or exercise program. If you know of any medical or other reason why participation in the LIVESTRONG at the YMCA program would be unwise for your patient, please indicate so on this form.

If you have any questions regarding the LIVESTRONG at the YMCA program, please contact one of the following:

YMCA Healthy Living Center at North River: Michelle McDougal at 423.877.3517	Fax: 423-777-4095
Downtown Family YMCA: Laura Reynolds at 423.266.3766	Fax: 423-265-5043
Hamilton Family YMCA: Ashley Barber at 423.899.1721	Fax: 423-899-7132
Cleveland Family YMCA: Dina Dell at 423.476.5573	Fax: 423-476-8842
North GA Community YMCA: John Donahoo at 706.935.2226	Fax: 706-935-2234

PHYSICIAN'S REPORT

My patient, listed above is:

_____ Not cleared to exercise at this time.

_____ Cleared to exercise with no restrictions.

_____ Cleared to exercise with the following restrictions and/or recommendations:

_____

My patient, listed above chooses the following program location:

_____ Downtown Family YMCA _____ Hamilton Family YMCA _____ North GA Community YMCA

_____ Cleveland Family YMCA _____ YMCA Healthy Living Center at North River

Physician Signature: _____