Medical Clearance Form

Date: Physician* Name:

Client's Name: Physician Phone:

Client's Phone: Physician Fax:

Client's DOB:

Dear _____,

Your patient _____ has requested to participate in LIVE**STRONG** at the Y: A Cancer Survivor Exercise Program at the YMCA of Greater Kalamazoo. 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 balance and flexibility test. Following the fitness assessment, your patient will partake in cardiorespiratory fitness, muscular strength and endurance, and flexibility and balance activities. A specific, individualized exercise program will be created for the participant based on the needs, interests and any recommendations you might have. The LIVE**STRONG** program is designed to start easy and become progressively more difficult over a 12-week period. All fitness assessments and exercise activities will be administered by qualified personnel trained in conducting exercise test and exercise programs.

Based on the LIVE**STRONG** at the YMCA intake form, your patient has indicated a diagnosed medical condition, coronary risk factor, and/or health condition that require a physician's clearance prior to participation in the LIVE**STRONG** at the Y 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 reasons why participation in the LIVE**STRONG** at the Y program would be unwise for your patient, please indicate so on this form.

If you have any questions regarding the LIVE**STRONG** at the YMCA program, please call or email the program coordinator listed below. Forms can be faxed to the number below. Thank you.

Program Coordinator: Shashu Baraka, 269-459-4856 or sbaraka@kzooymca.org Fax: 269-459-4873

Physician 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 below:

_____

Physician Name: _____ Specialty: _____

Physician Signature: _____ Date: _____

Physician Name: _____ Specialty: _____

Physician Signature: _____ Date: _____

Physician Name: _____ Specialty: _____

Physician Signature: _____ Date: _____

*You may need medical clearance from more than one physician. E.g. oncology, surgery, primary care.