Medical Clearance Form

Date: _____

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

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

Client's DOB: _____ Physician's Fax: _____

Dear Dr. _____,

Your client _____ has requested to participate in LIVE**STRONG**® at the YMCA: A Cancer Survivor Exercise Program at the Shiawassee Family YMCA. At the start of this program, your client 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 client 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 his/her needs and interests, and any recommendations you might have. The LIVE**STRONG** at the YMCA program is designed to start at an easy level and become progressively difficult over a 12-week period. All fitness assessment and exercise activities will be administered by qualified personnel trained in conducting exercise tests and exercise programs for cancer survivors.

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

If you have any questions regarding LIVE**STRONG** at the YMCA, please call:
Program Coordinator: Bill Archer Phone: (989) 725-8136 Fax: (989) 725-1581

Provider's Report:

My client, 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:

_____

Physician's name: _____

Physician's signature: _____ Date: _____