Medical Clearance Form
Westside Family YMCA

Date: Physicians' 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 LIVE**STRONG** at the YMCA: A Cancer Survivor Exercise Program at the _____ 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 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 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 patient, please indicate so on this form.

If you have any questions regarding the LIVE**STRONG** at the YMCA program, please call the program coordinator.

Program Coordinator: **LINDSEY COBAUGH** Phone (915) 584-9622
Return Fax (915) 833-6315

_____

Physicians 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

_____
_____

Physicians Name: _____

Physicians Signature: _____ Date: _____