Medical Clearance Form

Date:

Physician* Name:

Participant Name:

Physician Phone:

Participant Phone:

Physician Fax:

Participant DOB:

Dear _____,

Your patient _____ has requested to participate in LIVE**STRONG** at the Y: A Cancer Survivor Exercise Program at the YMCA of Greater Springfield, **Scantic Valley Y Family Center**. At the start of this program, your patient will participate in a fitness assessment, including a 6-minute walk test, one repetition max test for upper and lower body, and balance and flexibility tests. 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 12 weeks. All fitness assessments and exercise activities will be administered by qualified personnel trained in conducting exercise tests 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 requires 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 below on this form.

If you have questions regarding the LIVE**STRONG** at the YMCA program, please call or email the program coordinator listed below. Thank you.

Program Coordinator: Dawn Lapierre **Fax: 413.599.1475**

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 or recommendations** noted below:

_____

Physician Name: _____ Specialty: _____

Physician Signature: _____ Date: _____

Physician Name: _____ Specialty: _____

Physician Signature: _____ Date: _____

*We may need medical clearance from more than one physician. (oncology, surgery, primary care)