LIVESTRONG AT THE YMCA

MEDICAL CLEARANCE FORM

FOND DU LAC FAMILY YMCA
90 W. 2nd Street Fond du Lac, WI, 54935
P 920.921.3330 | F 920.921.3376

PATIENT INFORMATION

First Name: _____ Last Name: _____

Email Address: _____

Primary Phone: (_____)_____ Other Phone: (_____)_____ Date of Birth ___/___/___

PHYSICIAN INFORMATION:

First Name: _____ Last Name: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

PROGRAM INFORMATION:

Your patient listed above has requested to participate in LIVESTRONG at the YMCA, a cancer survivor exercise program at the Fond du Lac 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 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 LIVESTRONG at the YMCA program is designed to start easy and become progressively more challenging 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 LIVESTRONG 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 LIVESTRONG 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 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 our program coordinator.

Please return form to:

Program Coordinator, Jacob Berger P: 920.921.3330 x336 | E: jacob.berger@fdlymca.org | F: 920.921.3376

PHYSICIAN'S REPORT

TODAY'S DATE: ___/___/___ 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: _____