



Medical Clearance Form

Date:

Participant's Name:

Physicians' Name:

Participant's Phone:

Physician's Phone:

Participant's DOB:

Physician's Fax:

Dear Doctor,

Your patient has requested to participate in LIVESTRONG at the YMCA: A Cancer Survivor Exercise Program at the above designated 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 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 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 call:

- Rudi Hiney - North Canton YMCA 330-499-2587
Amanda Smith - Minerva Area YMCA 330-868-5988
Andrea Lee - Alliance Family YMCA 330-823-1930
FAX: 833-845-8450 ymcalivestrong@gmail.com

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: