



LIVESTRONG®

FOUNDATION

Medical Clearance Form

Date: _____ Physician's Name: _____

Client's Name: _____ Physician's Phone/Fax: _____

Your patient _____ has requested to participate in **LIVESTRONG** at the YMCA: A Cancer Survivor Exercise Program at the Y. 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. 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 that requires a physician's clearance prior to participation.

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 the program coordinator.

Program Coordinator: JACQUE PEREZ, Norm Waitt Sr. YMCA Wellness Director

E-mail: jperez@nwsymca.org Phone: 402-404-8439 Return Fax: 402-404-8444

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

Comments: _____

Physician's Name: _____

Physician's Signature: _____ **Date:** _____