LIVESTRONG at the YMCA Medical Clearance Form

Date: _____ **Physician's Name:** _____

Patient's Name: _____ **Physician's Phone:** _____

Patient's Phone: _____ **Physician's Fax:** _____

Dear Physician,

Your patient has requested to participate in LIVE**STRONG** at the YMCA: A Cancer Survivor Exercise Program at the New Canaan YMCA. At the start of this program, your patient will participate in a fitness assessment, including the 6-minute walk test, one repetition max test for upper and lower body, and a balance and flexibility test. Following the fitness assessment, your patient will take part 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 before 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 the form below. If you have any questions regarding the LIVE**STRONG** at the YMCA program, please call the program coordinator.

Program Coordinator: Eva Saint, Wellness Director at the New Canaan YMCA
Phone: (203) 920-1623; Return Fax: (203) 972-7738)

Physician's 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:

_____

_____

Physician's Name: _____

Physicians Signature: _____ **Date:** _____