



EMPLOYEE WELLNESS PROGRAM
 Division of Kinesiology and Health Science
 (714) 278-4404 / Fax (714) 278-5317

**Medical Clearance Form
 Exercise Class**

Name of Patient _____ Date _____

Your patient is interested in participating in an exercise class and fitness assessment being offered through the Employee Wellness Program at Cal State Fullerton. The program is under the direction of William Beam, Ph.D., associate professor in the Division of Kinesiology and Health Science. Dr. Beam may be reached at (714) 278-3432 or by email at bbeam@fullerton.edu if you have any questions.

The exercise class meets for one hour twice a week. The emphasis of the class is on strength training and aerobic training. The strength training typically consists of sets of 8-12 repetitions on a variety of strength training machines, free weights and floor exercises. It is recommended that the aerobic training be done at a "moderate" intensity, about 60-70% of heart rate reserve for 15-30 minutes. However, the participants may select to work at a higher intensity if it is appropriate.

Please indicate below for which of the following your patient is cleared to participate:

Strength training: () Yes with no limitations () Yes with limitations below () No cannot participate

Limitations _____

Aerobic training: () Yes with no limitations () Yes with limitations below () No cannot participate

Limitations _____

The fitness assessment could include measures of body composition, aerobic fitness, blood pressure, strength, flexibility and/or lung function. Aerobic fitness is measured through a graded exercise test conducted on a treadmill or cycle ergometer. The participant's heart rate and blood pressure and in some cases (depending on exercise risk) electrocardiogram are recorded during the test. The test can either be a submaximal test (typically stopping at 80-85% of the participant's heart rate reserve) or a symptom-limited maximum test. The test is NOT diagnostic, it is solely for the purpose of fitness assessment.

Please indicate below for which of the following your patient is cleared to participate:

Exercise test: () Yes with no limitations () Yes with limitations below () No cannot participate

Limitations _____

 Signature of Physician / Primary Care Provider

 Date

 Printed Name of Physician / Medical Group

Please return this form to:

 Street Address

Employee Wellness Program
 Kinesiology & Health Science, KHS-121
 Cal State Fullerton
 800 N. State College Blvd.
 Fullerton, CA 92834

 City State Zip

 Phone