Medical Clearance Form

Patient's Name:

Patient's Phone:

Patient's DOB:

Physician's Name:

Physician's Phone:

Physician's Fax:

Your patient has requested to participate in LIVE**STRONG** at the YMCA: A Cancer Survivor Exercise Program at the Southside Virginia Family YMCA. The program starts with a fitness assessment which includes a 6 minute walk test, one repetition max strength test for upper and lower body, as well as a balance and flexibility assessment. Throughout the program we will work on cardiorespiratory fitness, muscular strength and endurance as well as 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. LIVE**STRONG** at the YMCA is designed to start low and progress slow over a 12 week period.

Please do not hesitate to call if you have any questions or concerns regarding the LIVE**STRONG** at the YMCA program.

Thank you,

Elise Hemmer, Program Coordinator Phone: (434)-392-3456 Fax: (434)-392-6852

Please indicate level of participation and any limiting activities.

_____ **NOT** cleared to exercise at this time

_____ Cleared to exercise

_____ Cleared to exercise with the following **restrictions** and/or **recommendations**:

_____

_____

Physicians Name: _____

Physicians Signature: _____ Date: _____

PLEASE FAX REFERAL FORM TO (434)-392-6852 ATTN: Elise Hemmer