Whatcom Family YMCA LIVE**STRONG** Medical Clearance Form

Client's Name:_____ Physicians' Name:_____ Date:_____

Client's Phone:_____ Physician's Phone:_____

Client's DOB:_____ Physician's Fax:_____

Dear Doctor _____,

Your patient _____ has requested to participate **in** LIVE**STRONG** at the YMCA: A Cancer Survivor Exercise Program at the **Whatcom Family 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 LIVE**STRONG** 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 LIVE**STRONG** 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 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 this form.

If you have any questions regarding the LIVE**STRONG** at the YMCA program, please call the program coordinator.

Program Coordinator: Tammy Bennett Phone (360)255-0490
Return Fax (360)255-7098

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:_____

Whatcom Family YMCA
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