**STRONGHEART**
**Medical Clearance Form**

Date: __________ Physician's Practice: _________________

Participant's Name: _______________ Physician's Phone: _________________

Participant's Phone: _______________ Physician's Fax Number: _______________

Participant's DOB: _______________

The above named individual has expressed interest in participating in **STRONGHEART** at the YMCA: A Heart Health Education and Exercise Program at the Sumter YMCA. At the start of this program the participant will participate in a fitness assessment, including the step test, muscular endurance and strength test, balance and flexibility test. Following the fitness assessment, your patient will partake in cardio respiratory fitness, muscular strength and endurance, and flexibility and balance activities while self-monitoring blood pressure before and after exercise. A specific, individualized exercise program will be created for the participant based on the needs, interests and any recommendations you might have. It is designed to meet the client where they are at and progressively become more challenging over a 12 week period. All fitness assessments and exercise activities will be administered by a certified personal trainer who is trained in conducting exercise test and exercise programs.

Based on the participant's interest in this, he/she has indicated a history of cardiovascular disease, hypertension and/or high cholesterol that require a physician's clearance prior to participating.

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 program would be unwise for this individual, please indicate so on this form.

If you have any questions regarding the **STRONGHEART** program, please call the program coordinator.

Program Coordinator: __Cathy Mason___ Phone: (803) 774-2486

___________________________________________

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: _________