UR MEDICINE | THOMPSON HEALTH

Medical Clearance Form

Client: _____ Physician: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Dear Physician:

Please provide the following information to assist my senior fitness trainer in implementing my **physical exercise program.** Please verify this record with your signature along with your official stamp. Thank you.

Client signature: _____ Date: _____

_____ The client **may fully** take part in a physical fitness program including aerobic, muscular strength, and flexibility training without restriction.

_____ The client may take part in a physical fitness program as described above with the following recommended restrictions (please briefly note any special concerns or precautions you advise).

_____ The client **may not** take part in a physical fitness program as described above.

If the client uses any medication which may reduce exercise tolerance or alter heart rate or blood pressure response during exercise, please note:

If this patient's training heart rate should differ from that normally recommended for adults of the same age, please indicate the correct range (or, when applicable, note if THR values should be obtained from the patient's rehab center team):

Physician Signature: _____ Date: _____

*Such a program may include or gradually build up to: training sessions lasting approximately 1 hour on 3-5 days per week; progressive resistance exercise using no weights or light hand weights and, in some cases, gradually building up to moderate intensity training with variable resistance exercise machines; moderate low-impact aerobic training such as walking, stationary cycling, aqua class, or low-impact dance class at age-adjusted training intensities predicted to produce cardiovascular benefits. (All programming to be administered only as is apparently well tolerated).

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Medical Clearance Form

Client: _____ Physician: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Your patient is interested in taking a **test battery** designed to assess the underlying physical parameters associated with functional mobility (strength, endurance, flexibility, balance, and agility). The test battery was developed through research at the Ruby Gerontology Center at California State University, Fullerton.

All test items will be administered by training personnel. Participants will be instructed to do the best they can within their "comfort zone" and never to push themselves to the point of overexertion, or beyond what they think is safe for them. technicians have been instructed to discontinue testing if at any time participants claim they are suffering from, or show signs of dizziness, pain, nausea, or undue fatigue. The test items are:

1. Chair Stand Test (number of stands from a chair in 30 seconds)
2. Arm Curl Test (number of curls in 30 seconds; 5-lb weight for women, 8-lb weight for men)
3. 6-Minute Walk Test (number of yards walked in 6 minutes – person can rest when necessary)
4. 2-Minute Step Test (number of steps completed in 2 minutes)
5. Chair Sit and Reach Test (distance one can reach forward towards toes)
6. Back Scratch Test (how far hands can reach behind the back)
7. 8 Foot Up and Go Test (time required to get up from a chair, walk 8 feet, and return to chair)

If you know of any medical or other reasons why participation in the fitness testing by your patient would be unwise, please indicate so on this form. By completing the following form, you are not assuming any responsibility for the administration of the test battery.

If you have any questions about the fitness testing, please call 585-396-6700

_____ I know of no reason why my patient should not participate.

_____ I recommend that my patient **NOT** participate in testing.

_____ My patient should not engage in the following test items:

_____

_____

Physician Signature _____ Date _____

Print Name of Physician _____ Phone _____

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Informed Consent / Assumption of Liability Form

You are invited to participate in testing to evaluate your physical fitness. Your **participation is entirely voluntary;** you may decline to participate, and you may withdraw from participating at any time. If you agree to participate, you will be asked to perform a series of assessments designed to evaluate your upper – and lower – body strength, aerobic endurance, flexibility, agility and balance. These assessments involve activities such as walking, standing, lifting, stepping and stretching. The risk of engaging in these activities is similar to the risk of engaging in all moderate exercise. The most common risks include muscular fatigue and soreness, sprains and soft tissue injury, skeletal injury, dizziness and fainting. **However, there is also the risk of cardiac arrest, stroke and even death.**

If any of the following apply, you should **not** participate in testing without written permission of your physician:

1. Your doctor has advised you not to exercise because of your medical condition(s)
2. You have experienced congestive heart failure.
3. You are currently experiencing joint pain, chest pain, dizziness, or have exertional angina (chest tightness, pressure, pain, heaviness (during exercise)
4. You have uncontrolled high blood pressure (160/100 or above)

During the assessments you will be asked to perform within your physical "comfort zone" and never to push to a point of overexertion or beyond what you feel is safe. You will be instructed to notify the person monitoring your assessment if you feel any discomfort whatsoever, or experience any unusual physical symptoms such as unusual shortness of breath, dizziness, tightness or pain in the chest, irregular heartbeats, numbness, loss of balance, nausea, or blurred vision. If you are accidentally injured during testing, the test administrator will be unable to provide treatment for you other than basic first aid. You will be required to seek treatment from your own physician, which must be paid for by you or your insurance company.

You may discontinue participation in testing whenever you wish by asking to do so. By signing this form, you acknowledge the following:

1. I have read the full content of this document.
2. I have been informed of the purpose of the testing and of the physical risks that I may encounter.
3. I understand those risks involve muscular fatigue and soreness, sprains, and soft tissue injury, skeletal injury, dizziness, and fainting.
4. I further understand that risks also can involve cardiac arrest, stroke, and even death.
5. I agree to monitor my own physical condition during testing and agree to stop my participation and inform the person administering the assessment if I feel at all uncomfortable, or experience any unusual symptoms.
6. Should I suffer an injury or become ill during testing, I understand that I must seek treatment from my own physician and that I or my insurance company will have to pay for this treatment.
7. I assume full responsibility for all risk of bodily injury and death as a result of participation in testing.

My signature below indicates that I have had an opportunity to ask and have answered any questions I may have, and that I freely consent to participate in the physical assessment.

Print Name:_____ Signature:_____ Date _____

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HEALTH AND FITNESS QUESTIONNAIRE

Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Sex: _____ Age: _____ DOB: _____

Height: _____ Weight: _____

In case of emergency, contact _____

Relationship: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Please check the following items if the answer is YES and then provide further information as requested. Leave blank if NO.

_____ Has a physician told you recently that you should not exercise? If yes, why?
_____ Have you been hospitalized during the past year? If yes, why?
_____ Have you seen a physician for a medical problem within the last six months? If yes, when and why?
_____ Have you had any new illnesses or injuries within the last six months? If yes, please describe:
_____ Have you fractured any bone within the past year? If yes, which bone and on what date?
_____ Has a physician diagnosed arthritis in your case? If yes, please specify which type of arthritis (if known) and describe your symptoms?
_____ Do you often feel short of breath?
_____ Do you experience pain or discomfort in the chest?
_____ Are there any other medical concerns that you feel your instructor or trainer should be aware of in connection with your physical exercise program? If yes, please explain:

Please list all medications you are taking, including those prescribed by your doctor and all over-the-counter medications.

Below is a list of activities. Please check the appropriate column describing your ability to perform each task:

	NO DIFFICULTY	SOME DIFFICULTY	CANNOT PERFORM
Combing/washing hair			
Showering			
Bathing in tub			
Getting up from chair			
Getting out of car			
Climbing stairs			
Walking on level ground			
Carrying grocery bags			
Preparing meals			
Making/Stripping bed			
Tending lawn and/or flowers			
Light sports (i.e., bowling & Shuffleboard			

Are you currently involved in regular exercise? _____

If yes, please describe?

Please describe your goals for beginning or maintaining an exercise program at this particular time:

I have read and understand the previous questions and have listed to the best of my ability an accurate representation of my current health status. I am in good general health and have no limitations other than those I listed which might predispose me to risk during this program. If I experience any unusual symptoms during or following exercise, I will alert the instructor immediately. I understand that my personal trainer or instructor (name: _____) is the only facility representative who is familiar with my health status/history and medications in use. I will notify this instructor of any changes in my health status or medication regimen.

Signed: _____ Date: _____

Participant Instructions Prior to Assessment

Place: Thompson Health Rehab Services Department in Constellation Center

Date: _____

Time: _____

Although the physical risks associated with the testing are minimal, the following reminders are important in assuring your safety and helping you score the best you can.

1. Avoid strenuous physical activity one or two days prior to assessment.
2. Avoid excess alcohol use for 24 hours prior to testing.
3. Eat a light meal one hour prior to testing.
4. Wear clothing and shoes appropriate for participating in physical activity.
5. Bring the Informed Consent/Assumption of Liability and Medical Clearance forms, if required.
6. Inform test administrator of any medical conditions or medications that could affect your performance.

Note: As part of your testing, you will be asked to perform the aerobic endurance test below:

_____ 2-minute step test to see how many times you can step (march) in place in 2 minutes.

After you have determined that it is safe for you to participate in the tests (see Informed Consent/Assumption of Liability form), you should practice the aerobic test checked above at least once before test day—that is, time yourself either walking for 6 minutes or stepping (marching) in place for 2 minutes. This will help you determine the pace that will work best for you on test day.