Empower RI

Physician Activity Recommendations/Medical Clearance Form

Exercise Physiologist : Laura Gorriaran-Goodwin ACSM Identification Number 015489
Phone: 917-226-2274 **email:** lgtop1@yahoo.com

Doctor's name:_____

Practice name:_____

Phone:_____ **email:** _____

Dear Physician,

Your patient, _____ DOB _____, has applied for enrollment in the exercise programs at the Empower RI fitness wellness Studio. To determine a safe, appropriate exercise prescription and program, all participants fill out a Health Status Profile form. General health and lifestyle review questions are discussed and clarified by each individual in their first orientation appointment.

Exercise prescriptions are determined from physicians' recommendations and guidelines established by the American College of Sports Medicine. An initial blood pressure assessment might be followed by an optional submaximal. Other assessments may include body composition, muscular strength, muscular endurance, Functional Movement Screen and flexibility. A qualified practitioner will administer all fitness assessments and exercise programs.

After reviewing this participant's Health Status Profile, we determined medical clearance is needed to identify any limitations or restrictions for the client. By completing the form below you are not assuming any responsibility for our administration of the fitness assessment and / or programs.

If you have any questions about the EmpowerRI Wellness & Fitness, assessments and/ or exercise programs, please contact me at the above number.

I authorize the release of this information to EmpowerRI Wellness & Fitness.

Participant's name:_____

Participant's signature:_____**Date:**_____

Report of Physician

please check one

I know of no reason why the applicant may not participate
I believe the applicant can participate, but I urge caution because:

_____

The applicant should not engage in the following activities :

_____

Physician's signature:_____Date:_____

Empower RI

Physician Activity Recommendations/Medical Clearance Form

The Health Status Profile is designed to identify any health risk factors you have, which will help the Fitness professionals to modify an exercise program to meet your needs. If necessary one of our coaches may request clearance from your physician before you begin your exercise program.

Name_____ Age_____ Weight_____ Height_____ Gender_____

Address_____

Phone_____DOB_____

Assess your health status by marking all true statements

History:

You Have Had

- A heart or heart disease
- Heart surgery
- Cardiac Catheterization
- Coronary angioplasty (PTCA)
- Pacemaker/implantable cardiac device
- Heart Transplantation

You have diabetes
You have asthma or other lung disease
You have burning or cramping sensations in your lower legs when walking short distances
You have musculoskeletal problems that limit your physical activity

Symptoms

- You experience chest discomfort with exertion
- You experience unreasonable breathlessness
- You experience dizziness, fainting or blackouts

If you marked **ANY** of the statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. If you participate in our Healthy Start Orientation we will need your Doctor's information to send a medical Clearance Form

Other health issues

Cardiovascularriskfactors_____

- You are male older than 45 years
- You are a Woman older than 55 years
- You smoke, or recently quit smoking
- Your blood pressure is >140/90 mm Hg
- You take blood pressure Medication
- Your blood cholesterol level is >200 mg/dL
- You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)

_____ None of the above

You are physically inactive (i.e., you get <30 minutes of physical activity on at least 3 days per week)

If you marked **TWO OR MORE** of the statements in the section, consult your physician or other appropriate healthcare provider before engaging in exercise. If you participate in our Healthy Start

You should be able to exercise safely without consulting your physician.

My signature below verifies that I understand the above general health and lifestyle review questions and have answered each one completely and accurately. If for any reason my health conditions change and

any of my responses are no longer accurate, I will advise the Studio immediately by recording the change and presenting them to my practitioner.

Client signature:_____Date:_____