PHYSICIAN MEDICAL APPROVAL FORM

NAME OF PARTICIPANT: _____ *DATE* _____

The Rocky Hill Senior Center provides a number of health/fitness activities, programs and services for the apparently healthy individual. We would appreciate it if you would signify your approval for their participation in this program by completing the following questions.

1. Has the patient experienced any of the following symptoms of Cardiovascular Disease?

   _____ Palpitations or abnormal heart rhythms

   _____ Chest pain or pressure (angina type)

   _____ Dizziness or faintness upon exertion

   If so, please explain _____

   _____

2. Does the patient have any of the following Cardiovascular Disease risk factors?

   _____ Hypertension

   _____ Hyperglycemia or diabetes mellitus

   _____ Hypercholesterolemia of elevated blood lipids

   _____ Cigarette smoking

   _____ Family history of heart disease

   _____ Obesity

   _____ Sedentary lifestyle

   _____ Tension / stress

3. List any musculoskeletal injuries or problems, such as arthritis, that may be aggravated by exercise or that may limit an exercise program.

   _____

   _____

►

4. Please indicate any heart, fluid, blood pressure, seizure, diabetic or any other pertinent medications taken on a regular basis, and maximum heart rate not to exceed during exercise where applicable:

Medication:_____

_____Maximum Heart Rate:_____

Based on the preceding information, please indicate approval of the following exercises and equipment for use by filling in the appropriate boxes below.

_____ may participate in the following activities:
Please use a (+) to indicate approval and a (o) to signify contraindicated.

_____ flexibility

_____ walking program

_____ treadmill

_____ upper body ergometer

_____ calisthenics

_____ free weights

_____ elliptical cross trainer

_____ exercise bicycles

_____ aerobics

_____ low-impact

_____ general swimming

_____ aquatic exercise

_____ resistance machines (Nautilus)

_____ Nustep recumbent stepper

Exceptions/ restrictions on above exercises _____

_____

Recommend participation on the fitness program:

Full _____ Limited _____ (Comments, recommendations)

_____

_____

Physicians name: (please print) _____

Signature: _____ Phone: _____