To the Attending Physician of Mr./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient Name Birth Date*

Patient is classified as: (*Please check one*)

\_\_\_\_\_ 1. Group A: New enrollee in the Lifetime Fitness Program

\_\_\_\_\_ 2. Group B: Continuing participant

\*Patient understands that a medical examination is required before participation is permitted\*

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**To be completed by the attending physician**

The above named individual has asked to be included in a physical exercise program. The exercise program is operated 5 days/week for 2.5 hours and may involve moderate/strenuous exercise in the form of brisk walking/jogging, aquatic exercise, weight training, balance and flexibility training.

*Please indicate the conditions that apply to your patient. Leave those that do not apply blank.*

|  |  |  |  |
| --- | --- | --- | --- |
| *1.* | **Cardiovascular Disease**  **Dx:**  **Treatment:** | *8.* | **Peripheral arterial insufficiency** |
| *2.* | **CNS Disorders, especially:**   1. Epilepsy 2. Cerebrovascular disease | *9.* | **Paroxysmal or chronic disorder of the respiratory system:**   1. Asthma 2. Emphysema   Treatment: |
| *3.* | **Hypertension:** | *10.* | **Infectious Disease**  **Dx:** |
| *4.* | **Significant disorders of heart rhythm**  **Dx:**   1. Transient 2. Chronic | *11.* | **Diabetes:**   1. Type 1 2. Type 2   Treatment: |
| *5.* | **Hyperlipidemia** | *12.* | **Obesity** |
| *6.* | **Cancer**  **Dx:**  **Treatment:** | *13.* | **Other:** |
| *7.* | **Functional impairment of Musculo-skeletal system, especially:**   1. Arthritis 2. Back problems   **Explain:** |

**Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Known Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Prior or Current Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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The above-named individual is capable of:

Unlimited physical activity: \_\_\_\_\_\_\_

Limited physical activity: \_\_\_\_\_\_\_

No exercise program: \_\_\_\_\_\_\_

If the participant is cleared for limited activity, please offer exercise guidelines:

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*Physician’s Name (please print) Phone Number Hospital*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Physician’s Signature Date*

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*(Office Use only)  
LFP Staff Initials and date entered into database:\_\_\_\_\_\_\_\_\_\_*