Waldo County YMCA
Physician Clearance Form

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

At the Waldo County YMCA, your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine.

On the Personal Fitness Profile, you completed, you identified that you have one or more coronary and/or other medical risk factors which may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin your exercise program at the Waldo County YMCA.

We recognize that you are eager to start your fitness program, and we sincerely regret any inconvenience that this may cause you. Please keep in mind that we want your exercise experience at the YMCA to be as safe as possible. In order to expedite this process, we will gladly fax this form directly to the physician of your choice. If the doctor is aware of your medical history, he/she may be able to complete this form and fax it right back to us. In many cases the delay is only one day.

I hereby give my physician permission to release pertinent medical information from any medical records to the fitness staff at the Waldo County YMCA. ***All information will be kept confidential.***

Patients signature: _____ Date: _____

Information requested for: _____

Reason for medical clearance: _____

Healthcare Provider's Name: _____ Phone: _____

Address: _____ Fax: _____

FOR HEALTHCARE PROVIDER'S USE ONLY

Indicate any medication(s) which may alter your patient's exercise heart rate response or their ability to exercise.

Name of medication/purpose of medication: _____

Please check all that apply:

☐ Decreases exercise heart rate ☐ Increases exercise heart

☐ Heart rate should not be used as a method for measuring exercise intensity for this patient.

Please check one of the following statements:

☐ I concur with my patient's participation with no restrictions.

☐ I concur with my patient's participation in an exercise program if he/she restricts activities to: _____

_____

☐ I do not concur with my patient's participation in an exercise program.
Reason: _____

Healthcare Provider's Signature: _____ Date: _____

Please return via fax 207.338.2505 Attn: Tamera Blades

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