

GLENMEADOW RETIREMENT  
24 TABOR CROSSING  
LONGMEADOW, MA 01106

**EXERCISE CLEARANCE FORM**

**(page 1)**

**PATIENT'S INFORMED CONSENT AND AUTHORIZATION :**

I, (printed name) \_\_\_\_\_, desire to voluntarily participate in a Glenmeadow exercise program and/or fitness assessment. I understand the exercise program may include strength training, cardiovascular, flexibility and balance exercises, all of which may increase in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body mass index, flexibility, and muscular strength and endurance.

I understand that the level of exercise that I will perform is based on my medical history, physician's recommendations, and exercise tolerance. The exercise activities are designed to place a gradual increasing workload on the muscular, skeletal and cardiovascular systems. I understand that if I experience any pain, discomfort or shortness of breath, I should stop exercising immediately and notify staff.

I understand that there exists the possibility of certain changes to my body during or after an exercise session. I have been informed that this may include \_\_\_\_\_ (but is not all inclusive) : abnormal blood pressure, decreased blood glucose, fainting, irregular, fast or slow heart rhythm, and in rare instances a heart attack, stroke, or cardiac arrest. I have also been made aware that Glenmeadow does not require its staff to be CPR certified. In the event of an emergency, the staff will assist me and call the local ambulance and emergency medical support system.

I will also promptly provide to the staff any new health information that may affect my ability to safely participate in the program. I have been given the opportunity to ask questions related to this exercise program. I acknowledge that I have read this document in its entirety.

## EXERCISE CLEARANCE FORM

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I agree to voluntarily participate in the Glenmeadow exercise program and I consent to and authorize \_\_\_\_\_ to release to Glenmeadow Retirement, any health information concerning my ability to participate in the Glenmeadow exercise program described above. I understand that this consent for release of information can be revoked by me at any time, except to the extent action has already been taken. Any personally identifiable information obtained during this exercise program will be treated as confidential and only released to my referring physician. I agree to follow any limitations set by my doctor.

Participant's Signature:	Date:
Trainer's Signature:	Date:

### **PHYSICIAN'S RECOMMENDATIONS:**

Please complete the following recommendations for \_\_\_\_\_ to participate in a Glenmeadow exercise program by placing a checkmark before, and/or completing the statement.

#### **PLEASE NOTE:**

- 1. YOUR PATIENT MUST BE ABLE TO MONITOR THEIR OWN HEALTH STATUS DURING THE EXERCISE PROGRAMS.**
  
- 2. YOU MUST REVIEW ALL PARAMETERS WITH YOUR PATIENT.**
  
- 3. GLENMEADOW STAFF ARE NOT REQUIRED TO BE CPR CERTIFIED. THE EMS SYSTEM WILL BE CALLED IF NEEDED.**

	<b>A:</b> I am not aware of any contraindications toward participation in an exercise program.
	<b>B:</b> I recommend that any exercise program be subject to the following specific limitations:
	<b>C:</b> I recommend my patient <b>NOT</b> participate in the above exercise program

Physician's Signature:	Date:
Physician's name (print):	Phone:
Address:	Fax:
City:	State/Zip: