

Bernice Fonteneau Senior Wellness Center
3531 Georgia Avenue, NW
Washington, DC 20010
202-727-0338

Medical Clearance to Participate in the Physical Fitness Program

To: Primary Physician

Your patient _____ contacted the Bernice Fonteneau SWC regarding participation in the physical fitness program. This program involves access to both cardio and strength/endurance fitness equipment. All participants are encouraged to exercise their way up to 85% of their age predicted maximum heart rate.

Your permission is required in order for your patient to join the fitness center of the Bernice Fonteneau SWC. The attached Medical Referral form is intended to provide information about specific medical conditions. **Please note that the instructors are not medically trained.** Please use this form to indicate any equipment that the patient should avoid. Any extra information provided for your patient's safety would be greatly appreciated. Please contact the Bernice Fonteneau SWC at (202) 727-0338.

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Physician Clearance Form

Patient Name: _____ Date: _____

I consider this individual's health to be:

___ Normal ___ A Cardiac Patient ___ Prone to Heart Disease Other: _____

Please explain: _____

Date of last physical examination: _____ BP: _____ Cholesterol: _____

Check all that apply:

Present Activity

- Very Active
- Normal
- Limited
- Very Limited

Etiologic

- No Heart Disease
- Hypertension
- CAD
- Other

ECG

- Normal
- Abnormal
- Infarction
- Other

Rhythm

- Sinus
- Atrial Fib
- Sinus/ PVC's
- NSST Change
- Other

Specific cardiac/ pulmonary / metabolic diagnosis: _____

Additional abnormalities: _____

Present medication (please print): _____

My patient is able to participate in the following exercise programs:

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Recumbent Bikes | <input type="checkbox"/> Line Dancing | <input type="checkbox"/> Tai Chi | <input type="checkbox"/> Lower Body Weights |
| <input type="checkbox"/> Low Impact Aerobics | <input type="checkbox"/> Treadmills | <input type="checkbox"/> Yoga | <input type="checkbox"/> Upper Body Weights |
| <input type="checkbox"/> Chair Exercise | <input type="checkbox"/> Free Weights | <input type="checkbox"/> Stair Stepper | <input type="checkbox"/> Other |

Suggested Target Heart Zone: _____ to _____

Physician's Signature: _____

Name of Physician: _____ Phone: (____) _____

Address: _____ Zip: _____