THE DAVIS COMMUNITY

Seniors Pursuing Active Living®
Physician's Clearance Form

I hereby acknowledge that I have examined _____ on _____
(patient's name) (date)
and have found him/her capable of participating in the Wellness Program. The program will include the primary components of exercise including, but not limited to: Cardiovascular Training, Resistance Training, and Flexibility. Our facility will prescribe an exercise program based upon an in-depth fitness assessment, and by adhering to the American College of Sports Medicine guidelines for cardiovascular and strength training.

Will you please advise us which of the following exercise parameters you feel the above named patient **should** undertake in his/her exercise program?

Cardiovascular

___None ___Light-Moderate ___Moderate-Intense
___Light ___ Moderate ___Intense

Strength

___All ___Shoulders ___Chest ___Arms
___Upper Back ___Lower Back ___Torso ___None
___Legs Specific:_____

Flexibility

___All ___Shoulders ___Torso ___None
___Legs/Hips Specific:_____

Programs

___Body Core Class ___Basic Stretch ___Cardiofun ___Functional Strength

___Water Works ___Hydro Fit ___Hydro Blast ___Tai-Chi

Restrictions/Parameters

Please specify below, any situations/exercises we **should avoid**, and/or parameters we should follow

	No Restrictions
Cardiovascular/Pulmonary	Specify:_____
Muscular/skeletal	Specify:_____
Other	Specify:_____

- **Unless specified, all programs will follow guidelines established by the American College of Sports Medicine**

_____
Physician Signature Phone # Date

_____
Physician Name (please print) Physician's Address (please print)

Wellness Coordinator-Joseph Rouse **Fax #-910-319-2101**

_____ Please fax your reply
Sent by: (please print) (Wellness Coordinator's Name) (Wellness Coordinator's Fax #) to the facility

I, _____ consent to the release of all information necessary from my physician to satisfy the above document. By signing this document, I also consent to the correspondence regarding the above information between my physician and the Wellness Coordinator.

Print Name: _____ Signature: _____ Date:_____

Genesis Rehab Services