UR MEDICINE | THOMPSON HEALTH

Medical Clearance Form

Client: _____ Physician: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Dear Physician:

Please provide the following information to assist my Sports Performance Enhancement trainer in implementing my **physical exercise program.** Please verify this record with your signature along with your official stamp. Thank you.

Client signature: _____ Date: _____

_____ The client **may fully** take part in a physical fitness program including aerobic, muscular strength, and flexibility training without restriction.

_____ The client may take part in a physical fitness program as described above with the following recommended restrictions (please briefly note any special concerns or precautions you advise).

_____ The client **may not** take part in a physical fitness program as described above.

If the client uses any medication which may reduce exercise tolerance or alter heart rate or blood pressure response during exercise, please note:

If this patient's training heart rate should differ from that normally recommended for adults of the same age, please indicate the correct range (or, when applicable, note if THR values should be obtained from the patient's rehab center team):

Physician Signature: _____ Date: _____

*Such a program may include or gradually build up to: training sessions lasting approximately 1 hour on 3-5 days per week; plyometric exercise, high intensity training with focus on performance enhancement; moderate high-impact aerobic training such as jumping, weightlifting, running and dynamic movement patterns. (All programming to be administered only as is apparently well tolerated).

Medical Clearance Form

Client: _____ Physician: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Your patient is interested in taking High Intensity Training. This High Intensity Training was developed to improve your patients overall physical performance. Your patient will undergo a series of tests to formulate a baseline of physical condition and athleticism.

All test items will be administered by training personnel. Participants will be instructed to do the best they can within their "comfort zone" and never to push themselves to the point of overexertion, or beyond what they think is safe for them. Technicians have been instructed to discontinue testing if at any time participants claim they are suffering from, or show signs of dizziness, pain, nausea, or undue fatigue. The test items are:

1. Standing Long Jump (measurement of power generated in a straight plane from standing)
2. Standing Lateral Jump (measurement of power generated in a lateral direction from standing)
3. Standing Transverse jump (measurement of power generated in a transverse direction from standing)
4. Side Plank Test (measurement of core strength, stability and endurance)
5. Flexion Test (measurement of core strength, stability and endurance)
6. Push Up Test (measurement of upper extremity strength)
7. Wall Squat Test (measurement of lower extremity strength)

If you know of any medical or other reasons why participation in the fitness testing by your patient would be unwise, please indicate so on this form. By completing the following form, you are not assuming any responsibility for the administration of the High Intensity Training.

If you have any questions about the fitness testing, please call 585-396-6738

_____ I know of no reason why my patient should not participate.

_____ I recommend that my patient **NOT** participate in testing.

_____ My patient should not engage in the following test items:

_____

_____

Physician Signature _____ Date _____

Print Name of Physician _____ Phone _____

WAIVER AND RELEASE

I hereby agree to participate in the exercise and fitness program given by **Rehabilitation Services Department Sports Medicine of FF THOMPSON HEALTH** and its employees and agents (herein collectively Thompson Health), upon the understanding and conditions that:

I _____state that I am physically capable of participating in the fitness tests and vigorous exercise/fitness program and that, that to the extent necessary, in light of my prior health history, age, and general physical condition, I have consulted my personal physician or health authority before making such representations.

I recognize the risks of illness and injury inherent in any fitness testing and exercise/fitness program, and I am participating in the **HIT Sports Performance** program upon the express agreement and understanding that I hereby waive and release **Thompson Health** from any and all claims, costs, liabilities, expenses, or judgments, including attorneys fees and court costs (herein collectively "claims") arising out of my participation in the **HIT Sports Performance** program, or any illness or injury resulting there from.

I hereby further agree to indemnify and hold harmless **Thompson Health** from and against any and all claims, except claims purposely caused by gross negligence or willful misconduct of Thompson Health, its servants, agents, or employees.

I agree to inform the **HIT Sports Performance** instructor before participating in any of its' fitness testing and exercise/fitness programs of any change in my physical condition, including pregnancy, which might in any way adversely affect my ability to participate in the program safely.

In case of illness, injury, or disability (including pregnancy), I agree to obtain a written statement from my physician indicating that he/she still permits me to participate in its fitness testing and exercise/fitness programs, and to deliver same to my instructor prior to commencing (or continuing) such participation.

I hereby waive and release, and discharge any and all claims for death, hereafter accrue to me, as a result of my participation with the **HIT Sports Performance**. The release is intended to discharge in advance **Thompson Health**, employees, and agents from and against any liability arising out of or connected in any way with the participation in the **HIT Sports Performance** program. I further understand that serious accidents can occur during physical activity and that participants can sustain mortal or personal injuries as a consequence.

Knowing these risks of participation, I nevertheless hereby agree to assume those risks and to release and hold harmless all the persons or entities mentioned above (through negligence, careless or otherwise) might be liable to me or my heirs or assigns, for damages. It is further understood and agreed this waiver, release and assumption of risk is to be binding on my heirs and assigns.

I have carefully read, understand and agree to participate in the HIT Sports Performance program with the limitations set forth here.

_____ _____

Date Signature Of Participant

HEALTH AND FITNESS QUESTIONNAIRE

Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Sex: _____ Age: _____ DOB: _____

Height: _____ Weight: _____

In case of emergency, contact

_____

Relationship: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Please check the following items if the answer is YES and then provide further information as requested. Leave blank if NO.

_____ Has a physician told you recently that you should not exercise? If yes, why?

_____ Have you been hospitalized during the past year? If yes, why?

_____ Have you seen a physician for a medical problem within the last six months? If yes, when and why?

_____ Have you had any new illnesses or injuries within the last six months? If yes, please describe:

_____ Have you fractured any bone within the past year? If yes, which bone and on what date?

_____ Has a physician diagnosed arthritis in your case? If yes, please specify which type of arthritis (if known) and describe your symptoms?

_____ Do you often feel short of breath?

_____ Do you experience pain or discomfort in the chest?

_____ Are there any other medical concerns that you feel your instructor or trainer should be aware of in connection with your physical exercise program? If yes, please explain:

Please list all medications you are taking, including those prescribed by your doctor and all over-the-counter medications.

Below is a list of activities. Please check the appropriate column describing your ability to perform each task:

	NO DIFFICULTY	SOME DIFFICULTY	CANNOT PERFORM
Walking 3 miles			
Running 1 mile			
weightlifting			
Getting up from floor			
Performing multiple exercises			
Climbing/running stairs			
Sprinting 100 yards			
Carrying heavy weights			
Holding a squatted position			
Participating in highly aerobic sports			

Are you currently involved in regular exercise? _____

If yes, please describe?

Please describe your goals for beginning or maintaining an exercise program at this particular time:

I have read and understand the previous questions and have listed to the best of my ability an accurate representation of my current health status. I am in good general health and have no limitations other than those I listed which might predispose me to risk during this program. If I experience any unusual symptoms during or following exercise, I will alert the instructor immediately. I understand that my personal trainer or instructor (name: _____) is the only facility representative who is familiar with my health status/history and medications in use. I will notify this instructor of any changes in my health status or medication regimen.

Signed: _____ Date: _____

Participant Instructions Prior to Assessment

Place: Thompson Health Rehab Services Department in Constellation Center

Date: _____

Time: _____

Although the physical risks associated with the testing are minimal, the following reminders are important in assuring your safety and helping you score the best you can.

1. Avoid strenuous physical activity one or two days prior to assessment.
2. Avoid excess alcohol use for 24 hours prior to testing.
3. Eat a light meal one hour prior to testing.
4. Wear clothing and shoes appropriate for participating in physical activity.
5. Bring the Informed Consent/Assumption of Liability and Medical Clearance forms, if required.
6. Inform test administrator of any medical conditions or medications that could affect your performance.