



LIVESTRONG®

FOUNDATION

**YMCA of the Capital Area
LiveSTRONG at the YMCA Application and Medical Release Form**

LIVESTRONG at the YMCA is a 12-week physical activity and well-being program designed to help adult cancer survivors achieve their holistic health goals. The research-based program offers participants a safe, supportive environment focused on strengthen the whole person. The course includes two (2) classes per week, each lasting up to 90 minutes (including rest and reflection time). At the start of the program, your patient will participate in a fitness assessment which includes: a six-minute walk test, one-repetition max test for upper and lower body, and a balance and flexibility test. This is administered by a certified YMCA LiveSTRONG instructor.

Sessions are scheduled based on availability of locations and coaches. We anticipate sessions to be conducted during the Spring (March – May) and/or Fall (September – Early December).

Once we receive your completed application, you will be contacted to discuss locations. We will place you on the waiting list for that location at that time. Applicants are assigned to a session based on their availability.

APPLICANT INFORMATION (PLEASE PRINT AND COMPLETE ALL INFORMATION):

First Name: _____ Last Name: _____ DOB: ____ / ____ / ____

Phone Number: () _____ Email: _____

Type of Cancer Diagnosed & Date of Diagnosis: _____ Date of last treatment: _____

Participant Signature: _____
Date

TO BE COMPLETED BY PHYSICIAN/ ONCOLOGIST/NURSE PRACTITIONER (PLEASE COMPLETE ALL INFORMATION):

By completing this form below, you are not assuming any responsibility for the Y’s administration of the exercise program. If you know of any reason, medical or otherwise, why the applicant should not participate in the program, please indicate below.

- My patient is cleared to exercise with no restrictions
- My patient is not cleared for exercise at this time
- My patient is cleared to exercise with restrictions and/or recommendations: (Attach recommendation/restriction page)

Physician Name (Print): _____ Phone: _____

Contact Email: _____ Fax #: _____

Physician Signature: _____ Date: _____

Return completed forms to: jrussell@ymcabr.org or by fax (225) 924 – 3609

For questions regarding the program contact us by calling (225) 923-0653 ext. 1108 or visit the front desk of any YMCA Branch.

FOR INTERNAL USE ONLY:	Date Received: _____
Preferred Location: _____	Preferred Location #2 _____
Final Confirmation for Session (mo./yr) _____	