LiveSTRONG at the YMCA Application and Medical Release Form

LIVE**STRONG** 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. Applicants are contacted to schedule an Intake appointment closer to the start of a session. **Sessions are scheduled by location and timeframe based on requests by participants and by availability of location**.

APPLICANT INFORMATION (PLEASE PRINT): (Completed by applicant)

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

Street Address:_____ City/State_____ Zip: _____

Phone Number: ( ) _____ Email:_____

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

Check All Preferred Locations: _____ No Preference ___ A.C. Lewis ___Americana _____ C.B. Pennington ___DOW ___ ExxonMobil ___Paula G. Manship

Check Preferred Start Times: ___ No Preference ___ Before 10 a.m. ___ Lunch/Afternoon ____After 5:00 p.m.

Participant Signature: _____
Date

TO BE COMPLETED BY PHYSICIAN/ ONCOLOGIST/NURSE PRACTITIONER (PLEASE PRINT):

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: _____

_____

Physician Name: _____ Contact #:_____

Physician Email: _____ Fax #:_____

Physician Signature: _____ **Date:** _____

*For data purposes, please indicate how pre/post assessment should be sent: ☐ By Email or ☐ By Fax

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.