



Physical Activity For Life

An Outreach Program of the UBC School of Human Kinetics

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Changing Aging Program

Physician Clearance Form for Exercise

Participant name (please print): _____

Participant phone number: _____ Date: / /

Date of Birth: _____

Physician:

The above client would like to participate in the Changing Aging Program (a part of the Physical Activity for Life Program), housed within the UBC School of Human Kinetics, Faculty of Education, which requires physician approval. An exercise program will be prescribed after initial assessment of strength, cardiovascular endurance, balance and body composition, medical restrictions, physical limitations and your recommendations. These exercises will include an aerobic conditioning program along with core strengthening and balance, general body strengthening and flexibility. The information you provide will only be seen by the certified Personal trainers who set the exercise program. We understand the value of your time, and thank you in advance for filling this form out as completely as possible to help your client.

1. If you have treated, or are treating the above patients for any of the following conditions, please note where applicable.

	Now	Past	Comments
1. Cardiovascular condition	_____	_____	_____
2. Heart attack (MI)	_____	_____	_____
3. Congestive heart failure	_____	_____	_____
4. Stroke	_____	_____	_____
5. Heart surgery	_____	_____	_____
6. Chest pain	_____	_____	_____
7. Hypertension	_____	_____	_____

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|-------------------------------|----------|-------|----------------|
| 8. Hypotension | _____ | _____ | _____ |
| 9. Diabetes (type I) | _____ | _____ | _____ |
| 10. Diabetes (type II) | _____ | _____ | _____ |
| 11. Asthma | _____ | _____ | _____ |
| 12. Emphysema | _____ | _____ | _____ |
| 13. Dizzy spells/syncope | _____ | _____ | _____ |
| 14. Rheumatoid arthritis | _____ | _____ | _____ |
| 15. Osteoarthritis | _____ | _____ | _____ |
| 16. Cancer | _____ | _____ | _____ |
| 17. Gout | _____ | _____ | _____ |
| 18. Allergies | _____ | _____ | _____ |
| 19. Epilepsy | _____ | _____ | _____ |
| 20. Hernia | _____ | _____ | _____ |
| 21. Osteoporosis | _____ | _____ | _____ |
| 22. Osteopenia | _____ | _____ | _____ |
| 23. Anxiety syndrome | _____ | _____ | _____ |
| 24. Other | _____ | _____ | _____ |
| 25. Other | _____ | _____ | _____ |
| 26. Joint replacement/surgery | hip | L ___ | R ___ year ___ |
| | knee | L ___ | R ___ year ___ |
| | ankle | L ___ | R ___ year ___ |
| | shoulder | L ___ | R ___ year ___ |

2. Any significant musculoskeletal injuries?

3. Has this patient had a recent graded exercise stress test? Yes NO

If YES, what was the patient's MVO₂ ? _____ ml/kg/min

Did your patient become symptomatic during the GXT? YES NO

At what heart rate did the symptoms appear? _____ bpm

If NO, does this patient require one? _____ Protocol? _____

4. Cholesterol levels?	Total cholesterol	> 5.2 mmole/L	yes	no
	LDL-C	>2.6 mmole/L	yes	no
	Triglycerides	> 5.2 mmole/L	yes	no
	HDL-C	< 1.0 mmole/L	yes	no

5. Medication(s):

Please list the medications your patient is currently on, and dosages

Based on your patient's health status, please check one of the following:

A ____ Participation in the Changing Aging program is encouraged.

B ____ Participation in the Changing Aging program is advised with the following limitations and precautions: _____

C ____ I find participation in the Changing Aging program *not advisable* at this time.

Physician's name: _____

Physician's signature: _____

Physician's phone number: _____

To return this form to the Physical Activity for Life Program:

- 1. It may be faxed to 604-822-8998,***
- 2. It may be returned to your client,***
- 3. it may be mailed: UBC Changing Aging Program,***
6108 Thunderbird Blvd.,
Vancouver BC V6T1Z2

Thank you very much for your time and help. Any questions you may have, please phone Barry Legh, 604-822-1454, or e-mail barry.leggh@ubc.ca