

California State University, Fullerton

Balanced Fitness

MEDICAL CLEARANCE OF PERSONAL PHYSICIAN

Name of Patient _____

Your patient is interested in participating in the Balanced Fitness class, one of several physical activity programs offered by the Center for Successful Aging at California State University, Fullerton. The Center is under the direction of Debra Rose, Ph.D., professor in the Department of Kinesiology.

Initial Assessment: All program participants are required to complete a health/activity questionnaire to identify any medical conditions, medications, or other physical conditions that will need to be accommodated for during the class. The assessments to be conducted are identified below. Please indicate whether you approve of your patient completing each of these assessments in the space provided.

Physical Parameters	Assessments	Approval
Cardiovascular	* 2-Minute Step in Place	yes ___ no ___
	* 6-Minute Walk	yes ___ no ___
Flexibility	* Chair Sit and Reach	yes ___ no ___
	* Back Scratch	yes ___ no ___
Balance & Gait	* 8-Foot Up and Go	yes ___ no ___
	* 50 ft. walking speed	yes ___ no ___
	* Fullerton Advanced Balance Scale	yes ___ no ___

Exercise Program: The level of intensity of the program is based on the individual capabilities of each participant. The Balanced Fitness classes meet 12 weeks (twice/week for 75 minutes). Each class will be instructed by trained personnel/students with extensive education and experience in exercise science and aging. The class consists of a 10-15 minute warm-up, followed by 10-15 minutes of balance and mobility training, followed by 30-45 minutes of aerobic and resistance training. The class ends with a 10-15 minute cool down to improve flexibility.

Exercise Class Approval: yes ___ no ___

Please list any modifications/comments for testing and exercise class: _____

Patient's last blood pressure reading: ____ / ____

Please indicate by your signature below that your patient is medically cleared to participate in the specific portions of testing and training as described. Please call Dr. Debra Rose at 657-278-5846 if you have any question concerning the program.

Print Name of Physician

Signature of Physician

Date

Address: _____

Physician phone #: (____) ____ - _____

CALIFORNIA STATE UNIVERSITY, FULLERTON

Center for Successful Aging

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