

Lifetime Fitness Program
 215 Freer Hall, 906 S. Goodwin Avenue
 Urbana, IL 61801
 Phone: 244-6253 Fax: 244-7322

To the Attending Physician of Mr./Ms. _____
Patient Name *Phone Number*

Patient is classified as: *(Please check one)*

- _____ 1. Group A: New enrollee in the Lifetime Fitness Program
- _____ 2. Group B: Continuing participant

*Patient understands that a medical examination is required before participation is permitted.

To be completed by the attending physician

The above named individual has asked to be included in a physical exercise program. The exercise program is operated 5 days/week for 2.5 hours and may involve moderate/strenuous exercise in the form of brisk walking/jogging, aquatic exercise, weight training, balance and flexibility.

Please circle only the conditions that apply to your patient. Leave those that do not apply blank.

<p>1. Cardiovascular Disease: a) <i>Past</i> b) <i>Present</i></p>	<p>8. Peripheral arterial insufficiency of: a) <i>CNS</i> b) <i>Skeletal muscle</i></p>
<p>2. CNS disorders of residuals thereof, especially: a) <i>Epilepsy</i> b) <i>Cerebrovascular disease</i></p>	<p>9. Paroxysmal or chronic disorder of the respiratory system: a) <i>Asthma</i> b) <i>Emphysema</i></p>
<p>3. Hypertension</p>	<p>10. Infectious Disease</p>
<p>4. Significant disorders of heart rhythm: a) <i>Transient</i> b) <i>Chronic</i></p>	<p>11. Diabetes: a) <i>Type 1</i> b) <i>Type 2</i></p>
<p>5. Hyperlipidemia</p>	<p>12. Obesity</p>
<p>6. Cancer</p>	<p>13. Other:</p>
<p>7. Functional impairment of musculo-skeletal system, especially: a) <i>Arthritis</i> b) <i>Back problems</i></p>	

Medications: _____

Allergies: _____

Injuries: _____

Does the patient wear glasses? Yes No

Does the patient wear dentures? Yes No

PLEASE TURN OVER

(Office Use only)

LFP Staff Initials and date entered into database: _____

Medical Release Form

The above named individual is capable of: unlimited physical activity _____
limited physical activity _____
no exercise program _____

If the participant is to have their exercise limited, please offer exercise guidelines: _____

Physician's Name (please print)

Phone Number

Hospital

Signature

Date

(Office Use only)

LFP Staff Initials and date entered into database: _____