FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

MEDICAL CLEARANCE FORM

PARKINSON'S WELLNESS RECOVERY PROGRAM

YMCA OF GREENVILLE

Participant Instructions: Please complete this form (and secure an approval signature from your physician) prior to attending your first exercise class. Completed forms can be turned in to your instructor when you arrive.

Your Name: _____ Today's Date:_____

Your Date of Birth: __/__/___ Your Doctor's Name: _____

Diagnosis: _____ Date of Diagnosis: __/__/__

Current State of Diagnosis: _____

THE YMCA OF GREENVILLE'S PARKINSON'S WELLNESS RECOVERY PROGRAM ENTAILS:

1. PWR! Personal training (one on one)
2. PWR! and pedaling class combo (group exercise)
3. PWR! Circuit training (could be either one on one or in a group exercise setting)

PLEASE NOTE: YMCA of Greenville locations have AED's on-site, and our Wellness Coaches, pedaling instructors, and personal trainers are CPR certified and nationally certified to work with Parkinson's disease patients. The above-mentioned program formats are monitored by staff, however, If the patient comes into the facility on their own accord, their visit will not be individually monitored by staff.

THE PATIENT IS ELIGIBLE IF:

- The patient has a clinical diagnosis of idiopathic PD (the most common form of Parkinsonism in which the cause of the condition is unknown).
- Graded at Hoehn and Yahr stage I, II or III when off medication.

THE PATIENT IS INELIGIBLE IF THE FOLLOWING EXISTS:

- Clinically significant medical disease that would increase the risk of exercise-related complications (e.g. Cardiac or pulmonary disease, hypertension or stroke).
- Dementia as evidenced by a score less than 116 on the Mattis Dementia Rating Scale.
- Other medical or musculoskeletal contraindications to exercise.

Prescreening Questions for the patient to confirm with physician:

Have you taken any heart medications?	☐ YES ☐ NO
Have you ever had a heart attack?	☐ YES ☐ NO
Have you ever had heart surgery?	☐ YES ☐ NO
Have you ever had heart failure?	☐ YES ☐ NO
Have you ever had pacemaker/implantable cardiac defibrillator/rhythm disturbance?	☐ YES ☐ NO
Have you ever had cardiac catheterization?	☐ YES ☐ NO
Have you ever had coronary angioplasty?	☐ YES ☐ NO
Have you ever had heart valve disease?	☐ YES ☐ NO
Have you had a close blood relative who had a heart attack before age 55 (father or mother) or 65 (brother or sister)?	☐ YES ☐ NO
Have you ever experienced chest discomfort with exertion?	☐ YES ☐ NO
Have you experienced unreasonable breathlessness?	☐ YES ☐ NO
Do you take blood pressure medication?	☐ YES ☐ NO
Are you diabetic or take medicine to control blood sugar?	☐ YES ☐ NO
Is your blood cholesterol >240 mg/dl?	☐ YES ☐ NO
Females: Have you had a hysterectomy or are you postmenopausal?	☐ YES ☐ NO
Have you experienced dizziness, blackouts or fainting?	☐ YES ☐ NO
Have you experienced any falls within the last 3 months? If so, about how many?	☐ YES ☐ NO
Do you have musculoskeletal problems that would prevent you from exercising?	☐ YES ☐ NO
Do you have concerns about the safety of exercise?	☐ YES ☐ NO
Do you smoke?	☐ YES ☐ NO
Do you currently exercise fewer than 30 minutes per day/3 days per week?	☐ YES ☐ NO

Physician Clearance Section:

Do you recommend that this patient participate in the Parkinson's Wellness Recovery Program? ☐ YES ☐ NO

Physician Signature: _____ **Date:** __/__/__

Physician Name (Print): _____ **Phone:**_____

Address: _____

Fax: _____ **Hospital Affiliation:** _____

YMCA Staff Contact Name: _____ **Email:** _____

YMCA Branch Location: _____

Address: _____

Phone: (__)__-___ **ext.** _____ **Fax:** (__) __ - ___