YMCA of the Capital Area
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 assessment. This is administered by a certified YMCA LiveSTRONG instructor.

Sessions are scheduled based on availability of locations and coaches. We anticipate sessions to be conducted during the **Spring (March – May) and/or Fall (September – Early December**).

Applications are accepted on a continuous basis. Participants will be contacted once we receive a completed application, and they will be placed on a waiting list. Once a location is determined, along with time and dates, our team will call the waiting list to determine the applicants who are available to attend the session(s). Each group made up of 6 participants.

APPLICANT INFORMATION (PLEASE PRINT AND COMPLETE ALL FIELDS INCLUDING EMAIL):

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

Phone Number: ( ) _____ Email:_____

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

Participant Signature: _____
Date

TO BE COMPLETED BY PHYSICIAN/ ONCOLOGIST/NURSE PRACTITIONER (PLEASE COMPLETE ALL INFORMATION):
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: (Attach recommendation/restriction page)

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

Contact Email: _____ Fax #:_____

Physician Signature: _____ **Date:** _____

Return completed forms to: jrussell@ymcabr.org or 350 S. Foster Drive 70806

FOR INTERNAL USE ONLY: **Date Received:** _____

Preferred Location:_____ **Preferred Location #2** _____ **Final Confirmation for Session (mo./yr)** _____