VISITING NURSE ASSOCIATION
OF CAPE COD
Member Cape Cod Healthcare

Strong at Heart Exercise Program

Medical Clearance Form

Dear Medical Provider:

Strong at Heart exercise Program is an exercise program led by an Exercise Physiologist and designed for seniors who want to build on their strength and endurance. A mix of interval training and circuit training that will keep your heartrate up and muscles engaged. Participants must be able to tolerate 60 minutes of seated and standing exercise and ambulate independently. This program is recommended for generally healthy older adults, though modifications can be made on an individual basis.

Some focuses of this program are:

- **Improve cardiorespiratory health.**
- **Improve endurance and stamina.**
- **Increase mobility and flexibility.**
- **Increase muscular strength.**

Please complete the following:

I am not aware of any condition(s) that preclude the participation of _____
DOB _____, in Strong at Heart program. (Patients Name)

Patient was examined on or last seen:_____

Are there any limitations for participation? ☐ Yes (please specify below) ☐ No

_____

_____

Types of medication taken, history of cardiovascular disorders, diabetes, orthopedic problems, respiratory problems, convulsive disorders, etc. that may affect the participation in the Strong at Heart Exercise program?

_____

_____

_____

(MD Signature) **Date** **(MD printed name)**

Address: _____

Phone: _____ Fax:_____

For more information/questions regarding Strong at Heart Exercise Program, Please contact Amy Chipman at VNA Public Health and Wellness, 508-957-7423. This form may be faxed to: 508-394-2109

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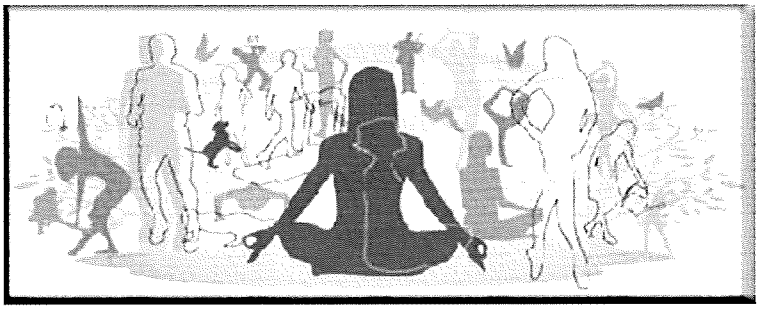
VNA of Cape Cod Wellness Programs

Participant Information Sheet



Participant Section:

I, _____, understand that I will be participating in the VNA of Cape Cod's Wellness programs, and to the best of my ability, I will attend every session of the program. I am also responsible to inform the staff of my health status each session.
If symptoms of distress, chest pain or other ailments are present, I understand that I will not be able to participate that given day. In addition, I hereby release Cape Cod Healthcare, its affiliates, and employees from any liability whatsoever occasioned by my participation in the programs.

SIGNED: _____ DATE: _____

PRINT NAME: _____ PHONE: ( ) _____

ADDRESS: _____ D.O.B. _____

CITY,STATE,ZIP: _____

EMERG CONTACT: _____ PHONE: ( ) _____

RELATIONSHIP: _____ PHONE: ( ) _____

******* This form along with the Medical clearance form from your physician is required to be returned to this office **prior to your participation in the program.**

This form is good for a period of 1 (one) year from above date.

~ VNA of Cape Cod ~ 434 Route 134, Suite G-1, South Dennis, MA 02660
Phone toll free: 1-800-631-3900 x 7423 or direct 508-957-7423 **FAX: 508-394-2109**