

EAGLE FIT PHYSICAL FITNESS

PARMED-X

PHYSICAL ACTIVITY READINESS MEDICAL EXAMINATION

From: _____

Date: _____

Dear Dr. _____

Your patient, _____, wishes to participate in a physical fitness assessment and subsequent exercise program with University of Mary Washington Campus Recreation.

The physical fitness assessment will consist of the following measurements: resting heart rate and blood pressure, body fat, upper-body endurance, flexibility and cardiorespiratory fitness. As exercise program, which may involve flexibility, cardiovascular and/or resistance exercises, will be developed based on the fitness assessment results.

Please review and complete the bottom portion of this form in regards to your patient's eligibility in participation in the Eagle Fit Program. This PAR med-X and release form will be maintained in a confidential manner and disclosed only to the patient and representatives of the Eagle Fit Physical Fitness Staff. If you have any questions, please feel free to contact me at (540) 654-1098.

Thank you,

This section to be completed by the participant

PERSONAL INFORMATION

NAME: _____

ADDRESS: _____

TELEPHONE: _____

BIRTHDATE: _____

GENDER: _____

PAR-Q: please indicate the par-q questions to which you answered YES

- Heart condition
- Chest pain during activity or rest
- Loss of balance, dizziness
- Bone or joint problem
- Blood pressure or hear drugs
- Other reason:

RISK FACTORS FOR CARDIOVASCULAR DISEASE:

check all that apply:

- Less than 30 minutes of moderate physical activity most days of the week.
- Currently smoker (tobacco smoking 1 or more times per week).
- High blood pressure reported
- High cholesterol level reported by physician
- Excessive accumulation of fat around waist
- Family history of heart disease

PHYSICAL ACTIVITY INTENTIONS:

What physical activity do you intend to do?

This section to be completed by the examining physician

PHYSICAL EXAM:

HT: ___ WT: ___

BP 1 ___ / ___

BP 2 ___ / ___

CONDITIONS LIMITING PA:

- | | |
|--|--|
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Exercise Test |
| <input type="checkbox"/> Abdominal | <input type="checkbox"/> Urinalysis |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other |

Test required:

Pregnancy: absolute/relative contraindications

	Yes	No
1. Ruptured membranes, premature labour?	<input type="checkbox"/>	<input type="checkbox"/>
2. Persistent second or third trimester bleeding/placenta previa?	<input type="checkbox"/>	<input type="checkbox"/>
3. Pregnancy induced hypertension or Pre-eclampsia?	<input type="checkbox"/>	<input type="checkbox"/>
4. Incompetent cervix?	<input type="checkbox"/>	<input type="checkbox"/>
5. Evidence of intrauterine growth restrictions?	<input type="checkbox"/>	<input type="checkbox"/>
6. High-order pregnancy (e.g., triplets)?	<input type="checkbox"/>	<input type="checkbox"/>
7. History of spontaneous abortion in previous Pregnancies?	<input type="checkbox"/>	<input type="checkbox"/>
8. Anemia or iron deficiency?	<input type="checkbox"/>	<input type="checkbox"/>
9. Malnutrition or eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
10. Twin pregnancy after 28 th week?	<input type="checkbox"/>	<input type="checkbox"/>
11. Other significant medical condition?	<input type="checkbox"/>	<input type="checkbox"/>

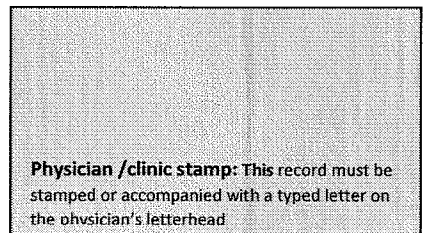
PARmed-X Physical Activity Readiness Convey/Referral Form

Based upon a current review of the health status of _____, I recommend:

- No physical activity
- Only a medically-supervised exercise program until further medical clearance
- Progressive physical activity
 - w/ avoidance of: _____
 - w/ inclusion of: _____
 - under the direct supervision of an Eagle Fit Personal Trainer
- Unrestricted physical activity

Additional comments you feel appropriate for your patient in regards to a fitness assessment and subsequent exercise program:

_____ 20 _____
 (date)



** Note: this physical activity clearance is valid for a maximum of six months from the date it is completed and becomes invalid if your medical condition becomes worse.