

# West Morris Area YMCA Parkinson's Program Physician Clearance Form

TO BE COMPLETED BY YOUR NEUROLOGIST/MOVEMENT DISORDER SPECIALIST OR PRIMARY CARE PROVIDER

Today's Date: \_\_\_/\_\_\_/\_\_\_ Patient's Name \_\_\_\_\_  
Patient's DOB: \_\_\_/\_\_\_/\_\_\_ Date of Parkinson's Diagnosis \_\_\_/\_\_\_/\_\_\_



Your patient wishes to participate in the **Rock Steady Boxing** (NON-CONTACT) exercise program. The activity may involve cardiovascular training (jumping rope, running, punching heavy bags), flexibility instruction (stretching, getting up & down on the floor), resistance training, and core strengthening techniques. Participants can attend up to 3 classes per week that are 60 minutes in duration. Participants may reach up to 90 percent of their maximum heart rate. Exercises are modified based on each individual's ability.

### PHYSICIAN'S RECOMMENDATION

- I am not aware of any restrictions on participating in this exercise program.
- I believe the patient can participate, but would urge caution (please explain): \_\_\_\_\_
- My patient should not engage in the following activities: \_\_\_\_\_

Your patient wishes to participate in **Fight Back UH2O** aquatic exercise program. The aquatic exercise program may include shallow water exercise, core strength, balance and agility, lower and upper body extremity strength, plyometrics, flexibility, stretching & relaxation. Exercises are modified based on each individual's ability.



### PHYSICIAN'S RECOMMENDATION

- I am not aware of any restrictions on participating in this exercise program.
- I believe the patient can participate, but would urge caution (please explain): \_\_\_\_\_
- My patient should not engage in the following activities: \_\_\_\_\_

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers or has no effect on heart rate response during exercise)

|                          |              |
|--------------------------|--------------|
| Type of medication _____ | Effect _____ |
| Type of medication _____ | Effect _____ |
| Type of medication _____ | Effect _____ |

### PHYSICIAN COMPLETES

\_\_\_\_\_ (Patient's Name) has my approval to begin the Parkinson's Exercise Program with the recommendations or restrictions stated above.

Printed name \_\_\_\_\_ Signature \_\_\_\_\_

### RETURN TO

Carly Heller carly@wmaymca.org  
West Morris Area YMCA  
(F) 973.366.8025 (P) 973.366.1120