UNIVERSITY OF MIAMI

PATTI & ALLAN HERBERT
WELLNESS CENTER

Living Independently
LIFE
wellness center
through Fitness & Exercise

Physical Clearance Form
(please present this form with the next page to your physician)

Dear Doctor:

Your patient _____ is interested in participating in the LIFE Program for seniors at the University of Miami Wellness Center. The program focuses on maintaining and increasing flexibility, muscular strength and decreasing the risk/fear of falling. Exercises include light/moderate resistance training (10 exercise circuit, 1 set of 12-15 reps), stretching, functional balance and agility exercises and walking. Our program is supervised by trained individuals with degrees in Exercise Physiology and/or certification through the American College of Sports Medicine. More program details can be found at www.miami.edu/wellness.

Due to the age and potential risk factors of your patient, we require your permission to allow him/her to participate in the program. If you would allow this patient to participate in our program, please fill out the form on the next page. If you have any additional questions, please contact me at (305) 284-8503.

Sincerely,

Tony Musto, Ph.D.
Director, Fitness Programs
ACSM Clinical Exercise Physiologist

Physician's Clearance Form

At the University of Miami Wellness Center, safety is our primary concern. For that reason, we comply with the health and fitness medical screening guidelines established of the American College of Sports Medicine.

On the medical history form you just completed, you identified that you have one or more medical risk factors which may impair your ability to exercise safely and/or increase the risk(s) involved with fitness testing. For this reason, you need to have your physician complete and return this medical clearance form before you can participate in our program.

We recognize that you are eager to start your fitness program and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your experience at the Wellness Center to be as safe as possible. In order to expedite this process, we will gladly send this form directly to the physician of your choice. If the doctor is aware of your medical history, s/he may be able to complete the form and fax it right back to us. In many cases, the delay is only one day.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at the University of Miami Wellness Center. All information will be kept confidential.

Participant Signature: _____Date:_____

Physician's name: _____Phone_____Fax_____

Wellness Center Staff Use Only

Clearance requested for:	
Service requested by patient:	
Reason medical clearance is necessary:	

For Physician's Use Only

Please check one of the following statements:

☐ I concur with my patient's participation in an exercise program/fitness testing with no restrictions.

☐ I concur with my patient's participation in an exercise program if s/he restricts activity to:
_____

☐ I do not concur with my patient's participation in an exercise program (if this box is checked your patient will not be allowed to participate).

Reason: _____

Physician's name (type or print):_____

Physician's signature: _____Date:_____

Please return or fax to:
Tony Musto, Ph.D.
ACSM Clinical Exercise Physiologist
Director, Fitness Programs
Fax # (305) 284-8517

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Rules of the game
(initial next to each statement)

1. I understand that as a L.I.F.E. Program member, I only have access to the Wellness Center on Monday, Wednesday, Friday during my selected class time. *_____ My preferred class time is: ___7am ___8am ___9am ___10am

2. I understand that I must check in at the front desk employee in order to gain entrance into the Wellness Center each time I use the facility. _____

3. I understand that if I do not attend the L.I.F.E. program for 2 weeks without notifying a staff member my place may be lost to a participant on the waiting list. _____

4. I understand that I may be denied participation in the program at any time due to physical, health, or any other concerns in which the professional staff is not qualified to address and/or the L.I.F.E. program is not appropriate. _____

5. I understand that upon completion of 36 visits my L.I.F.E. membership is expired; however, I do have the opportunity to renew my membership for an additional 36 visits. _____

6. I understand that I have 16 weeks to complete my 36 visits unless an extension is approved by Wellness Center staff. _____

*Does not include those with a regular Wellness Center Membership.

_____ _____
Participant's signature Date

_____ _____
Print Name Date

_____ _____
Witness Date

LIFE PROGRAM
INFORMED CONSENT AND RELEASE FORM

The participant understands that the LIFE Program involves activities to develop strength and endurance, aerobic capacity, flexibility, balance, and coordination. Activities include low to moderate resistance training and flexibility exercises. Resistance training includes a ten-exercise circuit consisting of one set of 12-15 repetitions.

Although participants are encouraged to proceed at their own pace, as with all exercise, some risk of injury is present. The participant has been informed that exercise may cause abnormal blood pressure, fainting, disorders of heartbeat, and in rare instances a heart attack. **The participant understands that if symptoms indicating an abnormality or distress such as fatigue, dizziness, shortness of breath, or chest pain appear they will stop exercising and report these to an instructor.** The participant understands that they may stop their exercise at any time for any reason.

The participant has been informed that there will not be a physician present during any of the exercise. The participant will have to be taken to a hospital if they develop the need for any emergency care, with the understanding that it will take time to travel from exercise site to the hospital. The participant further understands that, should such difficulties occur, the delay in time could be detrimental to them. The participant also understands that they are responsible for any medical expenses that they may incur as a result of illness or injury.

The participant understands that the practice of exercise science and the methods concerning these exercise classes are not an exact science and acknowledges that no guarantee or assurance has been given to the results of the exercises.

The participant understands that participation in the program is voluntary and that they may withdrawal from the program at any time.

The participant understands that all data collected may be used for research purposes but will not be linked to their identity. Participant records will be kept confidential to the extent permitted by law.

Participation in the LIFE Program and utilization of the University of Miami Wellness Center is at the participant's sole discretion, judgment and own risk. The participant assumes all risks of participating in the LIFE Program. The participant waives, releases, and discharges University of Miami, its board of trustees, the Department of Wellness and Recreation, and their employees and representatives from claims, actions, damages, liability and negligence for personal injury or damage relating to their participation in the LIFE Program and/or use of the University of Miami Student Wellness Center.

The participant, being mindful of his/her age, health and physical condition, agrees to voluntarily participate in the L.I.F.E Program for seniors. The participant has read the Informed Consent and Release Form, and understands and agrees with its content. The participant has had an opportunity to ask any questions they may have regarding the LIFE Program, and any questions have been answered to the participant's satisfaction.

Participant's signature	Date
Print Name	Date
Witness	Date