District of Columbia Office on Aging
Senior Wellness Centers

Physician Clearance to Participate in the Physical Fitness Program

To: Primary Physician

Your patient _____contacted the circled D.C. Office on Aging Wellness Center as indicated, regarding participation in the physical fitness program. This program involves access to both cardio and strength/endurance fitness equipment. All participants are encouraged to exercise their way up to 85% of their age predicted maximum heart rate.

Your permission is required in order for your patient to participate in physical activities program. The attached Physician Clearance Form (see reverse) is intended to provide information about specific medical conditions. ***Please note that the instructors are not medically trained.*** Please use this form to indicate any activities/equipment that the patient should avoid. Any extra information provided for your patient's safety would be greatly appreciated. Please contact the Wellness Center circled below for questions.

Please Circle the Wellness Center Location:

Ward 1: Bernice Fonteneau Wellness
3531 Georgia Ave NW
Tel: (202) -727-0338

Ward 4: Hattie Holmes Wellness
324 Kennedy St. NW
Tel: (202) -291-6170

Ward 5: Model Cities Wellness
1901 Evarts St. NE
Tel: (202) -635-1900

Ward 6: Hayes Senior Wellness
500 K St. NE
Tel: (202)-727-0357

Ward 7: Washington Seniors Wellness
3001 Alabama Ave SE
Tel: (202) - 581-9355

Ward 8: Congress Heights Wellness
3500 MLK Jr. Ave SE
Tel: (202)-563-7225

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Physician Clearance Form

Patient Name: _____Date: _____

I consider this individual's health to be: ____ Normal ____ A Cardiac Patient ____ Prone to Heart Disease

_____Other (Please Explain):_____
_____

Date of last physical examination: _____ BP: _____ Cholesterol: _____

Check all that apply:

Present Activity	**Etiologic**	**ECG**	**Rhythm**
☐ Very Active	☐ No Heart Disease	☐ Normal	☐ Sinus
☐ Normal	☐ Hypertension	☐ Abnormal	☐ Atrial Fib
☐ Limited	☐ CAD	☐ Infarction	☐ Sinus/ PVC's
☐ Very Limited	☐ Other	☐ Other	☐ NSST Change
			☐ Other

Specific cardiac/ pulmonary / metabolic diagnosis: _____
_____

Additional abnormalities:
_____
_____

Present medication (please print):
_____
_____

Allergies:_____

My patient is able to participate in the following exercise programs:

☐ Recumbent Bikes	☐ Line Dancing	☐ Tai Chi	☐ Lower Body Weights
☐ Low Impact Aerobics	☐ Treadmills	☐ Yoga	☐ Upper Body Weights
☐ High Impact Aerobics	☐ Free Weights	☐ Stair Stepper	☐ Other
☐ Chair Exercise	☐ Walking		

Suggested Target Heart Zone: _____to_____

The following restrictions, if any, apply before allowing the participant to partake in the program:
_____
_____

Physician's Signature: _____

Name of Physician: _____Phone :(_____) _____
(PLEASE PRINT)

Address: _____ Zip:_____